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# Health Teaching in Schools of Nursing

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Health and the subject of preventive medicine is one that has forced its way very rapidly to the foreground in medical and nursing circles. Heretofore all thought had been given to the critically ill patient but once recovery was in sight interest waned. Little attention was paid to the fact that the patient had not reached his former level of health.

When we discuss health concepts we are confronted with the vagueness of what health means. Dr. Williams, of Columbia University, gives as his definition: "Health is that quality of human life which enables the individual to live most successfully." Health, then, is not an end in itself but a means whereby the individual can function most adequately in society and reap the greatest reward that can be achieved—personal satisfaction in a task well done.

Health education is receiving a more and more important place in all types of curricula. We find it now on public school, collegiate and university schedules in one form or another. We must look about us for the reason of this change. Perhaps statistics compiled during the Great War have helped most to concentrate attention on the need of prevention of disease. It was found that large numbers of men, as a result of an illness incurred during childhood which might have been prevented or at least more adequately cared for, were physically unfit to serve their country.

At the close of the war, then, we have the nation confronted with the problem of disease prevention and health maintenance. There were also at that time overseas nurses waiting demobilisation and wondering just where they might again fit into society. The natural result of this situation was an increase in public health nurses whose chief activity was health teaching.

The laws of the country demand a certain standard of health in those publicly employed. These are minimum standards and not an ideal. Our ideal is that of positive health. We have thought of health as an absence of disease, but it is much more than that. Positive health is an ideal towards which we build, leaving behind all germs and all physical and mental imperfections. It will take years of work and much patience, however, before society can be made thus health conscious. We will need workers and teachers to whom health is of primary importance. Schools of nursing are the logical places to look for such aid. We are producing a group of professional people who should be prominent in the ranks of health leadership. A nurse has infinite opportunity to spread this gospel: consequently the onus is laid upon these schools for the provision of adequate health training for the students within their walls.

The question now arises—how shall we teach health? This, like all other

(Read at the annual meeting of the Saskatchewan Registered Nurses Association, 1931.)

subjects on our curricula, has two aspects. In a health programme they may well be:

(1) The maintenance and promotion of the personal health of the student.

(2) The realisation that all our nurses are potential health teachers and to qualify them to this end.

We must then commence with the student prior to her entrance to the school. It is essential that we must begin with a healthy individual. It is true that one meets with a certain amount of misunderstanding and lack of co-operation from the medical profession when one asks for a certificate of health. This is perhaps due to the fact that some doctors are not health conscious. The student should be required to present from a health officer proof of recent immunisation and vaccination. Probably the most satisfactory method would be to have the applicant examined by a physician selected by the hospital. This examination has a secondary value in that the student, before she enters the hospital is faced with the fact that health is essential.

If a man is going to be honest, he must be honest in all situations. If an individual is going to live wholesomely he must do so fairly continuously. Is it of any credit to a hospital that though its graduates have had a record of few ill days while students many are unfit for constant service after graduation? I venture to say that many here remember being on duty with a temperature and staying on. That may have trained one in endurance but it was far from being fair to either patient or nurse. All large organisations and factories take a primary interest in the health of their employees. They spend large sums of money yearly to supply an adequate health service. This is not for purely philanthropic reasons, but because it has proved its value in dollars and cents. Would it not be good salesmanship to consider our nurses in the same way? Some insurance companies consider it inadvisable to grant disability benefits to nurses. Does this raise a question in your minds?

A programme must be mapped out whereby a nurse shall be enabled to maintain her health. Several points might be considered here:

1. *Regular Health Examinations*: In our lectures on preventive medicine and oral hygiene we dwell upon the necessity of periodic examinations for the masses. Why not put our theory into practice by insisting that our students be examined periodically? Our students are examined yearly and also a few days prior to graduation. Such an examination is of twofold value:

(*a*) It checks over minor or chronic ailments of the student.

(*b*) It prevents future lost days.

In our recent examinations we found some students who required minor medical treatment. These were easily cared for when taken in an early stage and probably saved a lengthy loss of time in the future. This routine also sows in the student's mind the need of a periodic check-up both for herself and her patients.

2. *Number of Hours in Working Day*: A reasonable number of working hours is necessary for the maintenance of health. The nurse often overtaxes her strength by working many long hours caring for the sick. Nevertheless it is essential she should have a sufficient time for rest that she may be not only physically but mentally alert.

3. *Provision for Study and Sufficient Sleep*: The amount of sleep usually cares for itself in that most hospitals insist on lights out at ten-thirty and allow only a restricted number of late leaves. Study, however, is not as adequately cared for. Is it fair that a student must study after a physically hard day? All hospitals do not agree in their approval of the block system of classes but it surely should merit credit in that hours of study early in the day are provided.

4. *Recreation*: Health not only includes the physical aspect but the mental and moral also. Recreation is necessary for the former but also, if a school is to have intelligent students, there must be some opportunity for healthy mental stimulation away from the hospital. Time and opportunity must be allowed for this. If the student selects her mental and physical activities with care the moral aspect in most cases would need no further consideration.

5. *Healthful Environment*: This is largely controlled by the type of residence that the hospital provides.

6. *Dietary Needs*: Perhaps this is one of the most vexing problems. We teach our student what well-balanced diets for an adult should consist of but all too often she is given meals which are contradictory to what she has learned. Individual attention to diets for students requiring this service might be cared for by the diet kitchen. A monthly record of weights would aid in giving an index as to whether the student is being nourished. This is only of value if its findings are followed up.

7. *Time Allotment for Illness*: The law of Saskatchewan states that all employees must have one day's rest in seven. Teachers are allowed twenty ill days per academic year. Women in other walks of life are allowed a certain number of ill days. These workers have an added advantage in that their hours are shorter and they have a weekend in which to rest. Does it not, then, seem essential to allow a nurse a stated number of ill days in three years? In some hospitals it has been a custom to give a prize to the student who loses the least number of days off duty through illness. This seems to be contrary to health thinking. It will have the effect of encouraging the student to remain on duty when she would be much better off, so far as her patients, co-workers and herself are concerned. Health must be bought before it can be sold. Surely the criteria for judging the efficiency of the student's health service should be in relationship to her own general health. For good salesmanship, she must have what she intends to sell.

Let us consider the second aspect of health education: That is—To provide an education for the nurse that will qualify her to teach health.

The standard curriculum outlines a course of fifteen hours in Personal Hygiene. Dr. Grant Flemming, Medical Health Director of the Canadian Mental Hygiene Society, and Professor of Hygiene, McGill University, states that the way to teach hygiene to medical students and nurses is to teach it impersonally. If one is teaching health to Grade 1 pupils, then each morning the teacher can examine their hands for well-brushed nails, and give stars for brushed teeth. One does not do this with the adult. Furthermore, one must also consider the content of the course to be given. As I have said our students are potentially the health teachers of a few years hence. If this is so then they must be equipped professionally to cope with a professional problem. Our course must contain more than their school-day course of hygiene.

I understand the same problem is to be met with in normal schools. The student may often come in with very careless health habits and little idea of personal hygiene. She must be taught what to teach and how to teach it to her future pupils. It is gradually borne in on the normal school student that if she is to achieve success she must first, herself, practise these habits and be an example. In this light, it is also well to teach the student nurse. I have had our students this year each keep a daily health record during their preliminary months. These were started at the first hygiene class and kept daily for the succeeding four months.

To further stimulate interest the students are assigned health posters or scrap books. It is much more helpful to have a student nurse make her

own posters than to have her look at a number which have been made by companies. She must do a certain amount of health reading before she decides on a suitable way to make her poster. The student is advised to consult library reference books and health and nursing journals.

This spring the students were assigned scrap books. They were to assume they were teaching health in the lower grades and with this in mind to make a scrap book with pictures and stories that would illustrate health lessons.

I have found that much more interest is stimulated if the class is approached from the view point of what we shall teach to the other person. The student at this stage is particularly interested in patients. It must be borne in upon her that in her daily nursing care of patients many opportunities of health work are open to her. In fact, very often the only health work effected is done by the nurse. On the children's ward she has very many obvious opportunities to instill a little soap and water idea into Tony's mind and to tell little Mike all about the careless tram conductor who got the influenza—

"From the lady with the 'flu,
Because he put her nickel
Where he really ought to chew!"

These opportunities are fairly apparent but it is the patient on the medical floor perhaps who might very well profit by timely advice about her teeth which ought to be cared for, or perhaps she only needs a lesson on the efficacy of soap and water.

It is exceedingly difficult to instill into many nurses the science of preventive work. Nursing care is concerned not only with functions that relate to illness but also to all that work which leads to the restoration of the patient to physical and mental health. It is also concerned with the building up of his health concepts so that he will take better care of himself in the future. For this reason it is necessary to instill into the nurse at the very commencement of her education the idea of positive health as an aim for all persons. It is all too true that most nurses could recognise instantly a sick child but how many could tell when a child was really normal and well. We, then, at the very commencement of our course, help the nurse to realisation of her responsibilities on a health level. Her first experience in the maintenance of healthy surroundings for the patient is learned in hospital housekeeping. All the seemingly smaller activities of her first ward work and her care of convalescing patients are beginnings of her health work. It is during the care of convalescent patients that the student is afforded opportunity for health education. Quite often chances present themselves for spreading a little knowledge to patients, visitors and relatives. A tactful word here and there may do wonders.

We also make a practical application of our teaching. During the preliminary days the students receive two hours a week of physical education. They correlate this class to a certain extent with their physiology since they must know what muscles they are exercising with each different movement. After the students have passed their preliminary days they are given the opportunity to take swimming, and a dancing lesson once a week by a qualified teacher. This includes ball-room dancing and some fancy dancing. This summer we hope to have new tennis courts and possibly organised tennis for each student.

I think that after working hours more benefit is derived from an exercise in which there is an element of play.

In conclusion let me repeat that if we in our nursing schools are to keep abreast with the times we must give health education a very important place in our curriculum. Furthermore, the old theoretical method of health teaching will have to give way to a new and practical programme which the student not only studies but actually lives.

# Editorials

## *A Scientific Spirit*

Of the multiple interests claiming the attention of the nursing profession in Canada the most pressing is the Report of the Survey of Nursing Education in Canada, to be released from the press next month. In respect of magnitude and constructive value it is the most significant enterprise in which Canadian nurses have shared. For that reason and because of potential results which may accrue therefrom, it is of vital import that a large percentage of registered nurses should purchase and study the Report.

The Survey has made an attempt to discover the truth about nursing education and practice in this country. The truth, when revealed, should be viewed with open-mindedness, void of prejudice. In other words, the scientific spirit which actuated the launching of the Survey should characterise the individuals of the profession when reading the Report. Granted that spirit on the part of the reader, the sympathetic interpretation of data gathered together with the comprehensive recommendations of the document will ensure far reaching results.

Provincial, Alumnae and other groups will do well to devote several evenings during the coming months to a purposeful consideration of the various chapters. Several sessions of the general meeting to be held in Saint John, New Brunswick, next June will be given to a discussion of the salient recommendations made. Nurses from coast to coast should so familiarise themselves with the content of the report that constructive action may follow discussions in which their representatives participate.

Already steps have been taken to form small provincial study committees composed of medical and nursing representatives. Let that constitute precedent for further attempts of both individuals and groups to read and digest the Report. Such a procedure will secure maximum results for a considerable expenditure of both money and effort necessitated by the project. Provision has been made for the sale of the Report through provincial channels: a nurse member of the small study committee in each province will stimulate and direct the distribution. Obtain a copy. Bring to the study of it a mind open to conviction. The Report points the way to an improved profession in the decades to come.

*F. H. M. E.*

## *The Public Health Nurse in the Health Unit*

A great impetus was given to public health work with the establishment of the health units, first in England, then in the United States and Canada. These have proved very successful, as it shown by the further establishment of organised units. The great problem in Western Canada is that of rural health, and it would seem that all the advantages of a city health department for rural dwellers can only be accomplished by means of rural health units staffed with competent full-time workers.

The success of any unit rests primarily with the medical health officer,

but as in any field of medicine, behind him or rather shoulder-to-shoulder with him must be the nurse. The work of the public health nurse cannot be overlooked, as it is her privilege to come in possibly closer contact with the people than do the other members of the staff. In any unit, the nursing services will necessarily be along general public health lines and of an educational nature, including in its programme pre-natal, post-natal and infant welfare care, pre-school inspection, school inspection, home nursing instruction and inspection of nursing homes, visits regarding tuberculosis and trachoma, together with a newer phase included more and more, namely, that of mental hygiene. The definite organised unit tends to stabilise the public health nurse's position and provides for more complete co-operation. It becomes her own special "field to plough" and hers to see the results of labour expended

When a district's individual needs and problems can be studied and ways and means of aiding and improving health conditions are provided by a staff with the district's interest at heart, greater efficiency is likely to result. What an opportunity for the nurse with vision and initiative to become a part of the organised health unit!

*K. R.*

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## *Positive Health*

The term positive health has an attraction for those possessing a love of adventure, rather than the familiar "prevention of disease." To bring about a condition of positive health for society at large is almost Utopian: however, that should not deter the nurse from participation in such endeavour. It is recognised that such effort requires workers possessing infinite patience, perseverance, and deep-rooted altruism. Are our student nurses receiving guidance and instruction whereby they develop these characteristics, and will they become leaders in a positive health campaign?

A perusal of the curriculum in the majority of schools of nursing shows that the subject of personal health receives consideration from the theoretical standpoint. Are these theories applied as they should be? If so, wherein lies the explanation for many nurses breaking physically? Must it be admitted that our health concepts are too vague? Or do the careless habits of personal hygiene with which the young applicant enters the school remain unchanged during her training?

Whatever the answer to these questions, it must be admitted that nurses should conform to progress. Old methods must be replaced by a new and more practical programme so that each nurse may maintain a high level of personal health and become a leader in assisting all members of society to reach the same standard.

# *Some Newer Ideas About Syphilis*

By GEORGE S. FENTON, M.D., Ottawa

## PART I.

I must tell you how keenly I am sensitive to the honour you have done me by asking me to address you today.

For the past quarter of a century most of my work could not have been done without the assistance of trained, graduate, and registered nurses. For them I have developed a most profound and respectful admiration, sometimes, as it is on this present occasion, tinged with terror.

Men and women do work together in many employments: in factories, on farms and in offices; and always to some degree, at some time or other, there comes between them a nasty and unnatural sense of antagonism and hostility. Men think it unfair that they should have to compete with their sisters, and women feel that their very best work is depreciated because of its feminine origin. No such thought can ever trouble us in our profession. Here, the vast majority of you have perfected yourselves in those duties which, by your nature, you alone are fitted to perform. The whole world thinks that women are the only proper nurses; that no mere man could do such work as well. But all of this by the way. Perhaps, like the unjust steward of the Scriptures, I am trying to pillow my approaching downfall!

I was in some agony of mind over the choosing of a subject on which to speak. I did not wish to tell you only of things I had read about in books. Some of the books were bad; others I could not understand. And, too, it is quite natural, as you will presently find, that with increasing years the emphasis of memory is on what one has done, be it ever so little; on the peculiar experiences, however small, which have been encountered. Reading may give background, but the "memory-life," which is the only one left to us in later years, is nearly always determined by the good or evil we have done with our hands and brains. From this point of view, therefore, it did seem better that I should tell you something in connection with my own real, if unimportant, experience, rather than to relate probably false impressions of something I had read.

For the last six years it has been my good fortune to have charge of a clinic conducted, somewhat surreptitiously, by the Ottawa Day Nursery for the treatment of syphilis in women and children. Every Thursday afternoon from twenty-five to fifty of them pass through my hands. It is about this disease that I shall speak. I must warn you that while my sayings cannot be new or original, they will be coloured and biased by the experience I have gained in my work.

You will allow me to recall a few of the most interesting facts and fancies concerning syphilitic infections. The germ itself, the causal organism, is a most interesting bacterium. Spirochæta pallida, the pale, translucent spirochæta, is probably the most beautiful of all germs. It looks exactly like a delicate and perfectly symmetrical corkscrew; it has from three to twenty-odd spirals, and is long enough to stretch across two red blood cells. The organism has a very short life outside the living body. Probably under no condition will it live for twenty-four hours. To this delicacy of constitution the human race owes much. Were the spirochæta a strong, hardy, resistant organism, the number of cases of syphilis acquired by innocent and casual contacts would be legion.

(A paper given by Dr. Fenton at a meeting of District No. 8, Registered Nurses Association of Ontario, on May 16th, 1931, at Renfrew, Ont.)

The way in which this spirochæta gains entrance to the body is worthy of note. It is generally conceded that there must be touch-contact between broken skin or mucous membrane (it does not matter if the break be unnoticeably small), and a part of the infecting person or article where the organisms are superficial and alive. This means a lot. It means that a whole skin probably gives perfect protection—even though perfectly whole skins are rare. In view of the short life of the organism outside the body, it means that indirect contagion is usually improbable. It means that the most contagious period in syphilis is the early period, the first few months, when the organisms are most likely to be touchable; that is, on the skin in primary sores or in early rashes or in the ulcers of mucous membranes. Probably the greatest danger of contagion exists when the superficial sore is placed where it cannot be seen. The majority of infections are acquired through hidden lesions of the cervix or the vaginal mucous membrane.

Once having gained entrance, the spirochætae multiply exceedingly in the superficial lymph spaces, and in the course of a few days or weeks have caused so much local disturbance that the tissues react to form what is called the primary sore or chancre. So much attention used to be paid to this first visible evidence; chapters have been written on its diagnosis and treatment, but this great truth has come to be known: that by the time the primary sore has developed into a recognisable lesion, the infection has entered the blood stream and is circulating throughout every part of the body. It was like paying minute attention to the size, shape and colour of the stable door long after the horse had departed. By the time the chancre can be seen you may be sure that the organisms found in it are merely the rear-guard of a landing party whose teeming millions have gone upstream into the far interior. A man who contracts syphilis has a local lesion for a few days, and a generalised infection for the rest of his life.

Usually the first ocular proof of the generalised invasion of the bloodstream is the syphilitic rash. And if you will reflect a moment you will realise that the same blood which bears spirochætae to the skin also is carrying them to every other tissue and organ, where it circulates; to the innermost marrow of the bones; to the most remote and delicate tissues of the brain. There is an inside rash, an endanthem.

At first, in the bloodstream, the invading myriads engage in house-hunting. They are like colonists looking for suitable homesteads. But soon they choose their places and settle down, often, at first, with very little disturbance to the surrounding cells and tissues. And there they stay, alive for years and years: probably till twenty-four hours after the death of the infected person. They may never cause serious trouble or they may bring the most repulsive death. They have the power to remain quietly hidden though alive, to remain latent. Latency is one of the most distinctive and significant characteristics of syphilis. Tuberculosis is far behind it in this respect. For instance, and a true instance: A boy contracted syphilis in his eighteenth year. The little treatment he received at the time appeared to clear up everything. There were no further symptoms and the incident passed from his memory. He became a good athlete and made good progress in his profession until his forty-fifth year. Then he began to act peculiarly, and still more, so peculiarly that he lost his position. He became slovenly in appearance and absolutely impossible as a companion. Within a year his doom was definitely sealed. He had general pareisis of the insane. He had become much lower than the beasts of the field.

What happened? Early in his infection some of those house-hunting spirochætae in the bloodstream chose

to settle in his brain. There they lived without offence for thirty-seven years. Then they left their peaceful habitation and bestirred themselves to destroy the whole of that man's brain. Thirty-seven years with never a visible sign or warning! Why, the man even got his life insured three times!

Any time, anywhere, anyhow, latent, quiescent, hidden syphilis may rouse itself to produce destruction in any part of the body of the host. As a matter of fact, certain tissues do more often suffer this delayed disaster. Commonly they are skin, blood-vessels, nerve and bone, probably in that order of frequency. It is because of this characteristic of the infection, this possibility that after long latency it can produce such disturbance in any part of the body—disturbance with all variety of signs and symptoms; because of this that our Fathers in Medicine used to say, "Know syphilis and you know all diseases."

From what I have said, I hope it appears that time, the passing of time, has much to do with syphilis. It is usually a lifetime matter. And when we come to diagnosis, time is of transcendent importance. Formerly we diagnosed syphilis by using our brains. We had to depend on our observation of the signs and symptoms of the disease. This was a slow way. Before a definite opinion could be formed the infection had spread throughout the system. Nowadays, with much greater speed and greater average accuracy, we use a microscope or a few test-tubes.

You will remember I have mentioned that for a short while the infecting agent of syphilis remained at the point of entry. And just at this stage we have, for a few days, a golden opportunity for an attempt at cure which holds good prospect of perfect success. A primary sore quickly recognised and its possessor thoroughly treated means that, in all likelihood, no further signs or symptoms of syphilis will ever appear. This quick method requires a dark-field microscope. If we can secure a drop of tissue juice from this place and examine it with such an instrument we can answer yes or no to the question of syphilitic infection at once. There is no other way to be sure. A chancre may look like nothing or anything. Experience has shown that proper and adequate treatment given at this stage offers very good assurance of permanent cure. Unfortunately the dark-field microscope requires some little skill and experience in its technique. In principle it is perfectly simple. You may compare the dark-field itself—that is, the drop of material which you are examining—to, say, a ward which has just been "done up" by one of you. Spick and span and shiny it is, without a particle of dust anywhere—except perhaps on the top of the door and in a very farthest corner. The air is perfectly clear: until a ray of strong sunshine throws itself in from the window—and there, in a beam of brighter slanting light, appears a countless myriad dancing particles of dust; enough to shame the most junior probationer. That is what the dark-field attachment does to a microscopic field. It shades down the high illumination of the whole field and throws a strong oblique beam of light through the comparative dimness in the drop of fluid. And like the dust in the room, particles appear which previously were invisible. Such a field is one of the most beautiful sights a microscope has to offer. Against the dull background of the surrounding fluid, the spirochætae show in silver-white coils of perfect symmetry, moving with slow, stately and graceful determination. It gives the greatest possible contrast to a field of typhoid baccilli at play in their hanging drop—dashing about aimlessly in fitful wriggles with no apparent reason or object.

Since the success of the treatment of syphilis is invariably and directly in proportion to the promptness with which treatment is begun and since no human eye can always surely know

all the outward marks of the disease, dark-field examination of material from suspicious localities is, of all other procedures, the most necessary and important. Treatment begun at this early date, say, within three weeks of infection, is almost sure to be efficient and very probably of permanent effect.

But supposing this has not been done, we must fall back upon our second quickest method of diagnosis. This is the test-tube procedure; the blood-test of Wasserman or Kahn. These famous reactions are not really direct evidence of syphilis. They show that the tissues of the infected person have developed a substance to fight the invasion; that a syphilitic antibody is present in the blood. It is an indirect, a negative inference as to the presence of syphilis. Just as if, passing a fire-station, you saw through its wide-open doors that all the men and apparatus had gone; without seeing the fire you might be fairly sure that somewhere something was burning. These reactions, the Wasserman and Kahn, are probably given, at some time, by most tissue juices. Notoriously the examination of spinal fluid obtained by lumbar puncture often gives us startling warning of danger, either actual or threatened, to the nervous system. A *positive* Wasserman may be shown by the spinal fluid long before we think the nervous system could be affected. It may remain long after other tests have become *negative*.

Another interesting test-tube procedure which has developed in connection with spinal fluid is the colloidal gold reaction. When syphilitic change is present in the nervous system its fluid acts in a peculiar way when it is mixed with solutions of colloidal gold of accurately varying strengths. The measure of this test is given by the change in the colour of the gold solutions in the test-tubes. To begin with it is a pretty pink shade; when it is mixed with the tainted spinal fluid the series of test-tubes fades through an array of blanching heliotropish purples. The different successions in which the shades appear give us a hint as to what part of the nervous system is being marked for destruction. Arranged in order and numbered, they are plotted into what are called colloidal gold curves. One such, resembling a toboggan slide, suggests general pareisis; another showing a hump in the middle forbodes tabes dorsalis.

Incidentally, these tests also show that the spirochætae have spread from their landing-place and multiplied so greatly that a general alarm has been turned into the bloodstream. When blood tests have become *positive* it is likely that three weeks of valuable time have been lost. But even now, if proper, intensive, adequate treatment be started and kept up, it is likely that all evidence of the disease will disappear forever. It is all a matter of time: of prompt, accurate diagnosis and of quick, efficient and long-continued treatment.

The reason, of course, is quite simple. Cure means the killing of all the spirochætae wherever they may be. To kill them the remedy used must be brought into direct contact with them, and this is obviously most easily done when they are lying loose in the initial lesion or floating freely in the accessible body fluids, before they have had time to dig themselves into the remote, inaccessible fastnesses of the body. The first question of the syphilitic, when he knows his state, is "How long till I'm clear of it?" Before an answer can be given, one must ask, "How long have you had it?" Generally, and with approximate truth, the chance of cure depends on the promptness of diagnosis.

(Concluded in next issue.)

# *Parent Training*

By R. R. STRUTHERS, B.A., M.D., Montreal

In the course of my lectures to the Senior Class last year I remarked, in discussing certain faults and peculiarities of infancy and childhood, that these difficulties in the training of children were not of themselves the fault of the child, but rather showed the lack of training on the part of the parents. You will all agree with me, I think, that there is no equally serious undertaking which we assume in life with as little preparation as that of the upbringing of our children. I wish to discuss briefly these apparent faults in early childhood.

It is my contention that there is no one thing which we, either as parents or potential parents, can hand on to our children which will be of such inestimable value to them in later life, as a stable nervous system. By a stable nervous system, I mean particularly, good emotional control, and the only way we can inculcate in our children good emotional control, is by precept and example. It cannot be done by teaching or by actual conscious effort directed towards the child's emotional life. It can only be done by example. The emotional life of the child is essentially founded on the emotional life of its parents, who compose his environment and, as I shall point out to you, we can practically always trace back the emotional disturbances of young children, to emotional disturbances in their environment. Such tracing back is of necessity a laborious, time-consuming procedure and unless, in the investigation of such disturbances, we are prepared to expend long hours of patient questioning, it is much better that we should forego the attempt to elucidate the emotional disturbances of young children.

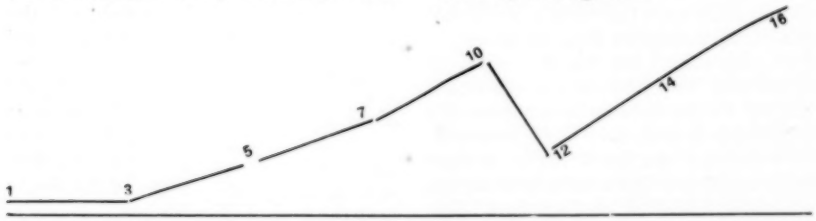
Emotional control as regards the young child may be divided into two phases; first, self-control as we ordinarily understand it, particularly as regards the thwarting of immediate desires, and second, independence. By independence we mean two things—independence of self as regards depending on self for satisfaction of emotional desires, of which I shall speak later, and also independence of parents in regard to the securing of satisfaction of desires, such as ability to do things for himself, that is, emotional control in the language of the psychologist requires extroversion of ideas for emotional development rather than intraversion: looking towards self for satisfaction of emotional life. These ideas will be made more clear, perhaps, as my theme develops.

If you will regard the emotional life of the child up to the age of puberty as a straight line, thus up to the age of two or three years the child's demands are entirely personal or selfish and the distance between desire and accomplishment must of necessity be short. This is best shown by the example of the young infant, who, when hungry, and satisfaction of his hunger is not immediately forthcoming, immediately gives an emotional display in the form of crying, which we regard as being an essentially normal manifestation, that is, the distance between the desire and the period of attainment is short. After the age of two the child's emotional life as regards play and interest is much more dependent on outside interests in the form of toys, diversions, such as books and playmates, and the absolute dependence on self is much less marked, so that the distance between desire and attainment may be much greater. That is to say, thwarting of the immediate desire is much more readily borne, and the child learns to accept thwarting for the moment and the postponement of the actual attainment of his

(A lecture to the School for Nurses, Montreal General Hospital, 1931.)

desire until some more distant date. Hence, the distance between desire and attainment becomes more prolonged as the child increases in age and learns to accept such thwarting. In ordinary language we may state this condition to be the ability to become accustomed to making his desires co-ordinate with the family life around him. The acceptance of such thwarting of desire, thus making himself by this means a pleasant attractive member of his household, is the thing which we all admire, though unconsciously, in the child whom we call "well-trained" or "well-behaved." He is essentially a pleasant member of his household and is not the small emperor of his kingdom, whose every desire requires immediate attention, which is the form of tyranny we are accustomed to associate with the so-called "badly behaved" or "ill-trained" child, who expresses his slightest thwarting by an emotional display.

It is necessary in this regard to say a few words concerning the so-called sexual life of the child. Because of the child's complete dependence on self for emotional activity during the first year or two, there arise certain auto erotic manifestations which we are accustomed to consider "bad habits," such as masturbation, thigh rubbing and thumb sucking. These are of themselves not necessarily bad habits, with evil consequences, but simply bear out the idea that the child is essentially dependent on self for emotional satisfaction. That is, the distance between desire and attainment is very short because these habits apparently do give a certain amount of satisfaction, and their fulfilment is dependent on no outside influences, but the attainment of the desire can be made immediate. On the other hand, it is well known that such habits tend to disappear when the child becomes less dependent on self for emotional satisfaction, and such habits, due to the distribution perhaps of the child's attention by outside interests after the age of two, tend to become less frequent or to disappear. That is, this form of auto erotic manifestation tends to disappear from the age of three until the age of pre-puberty, when, the physical changes going on in the organism and the oncoming signs of maturity, once more centres the child's emotional life on himself and such erotic habits again may become manifest. In the case of the child whose emotional life has been well organised from the ages of three on to pre-puberty, such interest in self tends to gradually disappear and the child passes through what is admittedly the difficult emotional period of puberty and he becomes again the less self-centered individual, which he was before, as regards his emotional life. This idea can perhaps be best illustrated by a diagram:




The whole question of so organising the child's emotional life during this training period of from three to ten or twelve is dependent on his emotional surroundings, that is, on his parents. If I have made myself clear on these points, which on the face of them may have little to do with the question of parent training, I will attempt to show you the relationship of such training to the future development of the child.

Those children whom we are accustomed to call emotional children or

nervous children, are characterised by certain physical peculiarities. First, as regards appearance, such children are usually lean, poorly nourished; they have a fickle appetite, poor digestion as shown by frequent digestive disturbances, sleep poorly, tire easily, have poor ability of mental concentration and are incapable of sustained mental or physical effort. In addition they fall readily into those mannerisms which, for lack of a better term, we are accustomed to call "bad habits." These so-called bad habits can practically always be traced to some malign influence in the child's environment, particularly as regards the lack of good emotional control in parents, nurses or teachers. The number of these so-called bad habits is great and it is my desire simply to enumerate a few of them to you and see how they best can be related to some similar, equally pernicious habits, in the adults about them.

First, *Fear*. Fear is a habit of mind which we are accustomed to associate with some other previous experience. This is not true in the case of the majority of children. The great majority of children who are afraid, of the dark for instance, have had no unpleasant emotional experience associated with the lack of light, but are simply imitating the attitude of the adult members of the family. True, the mother may have had some unpleasant experience in the dark which, due to her lack of emotional control, she is involuntarily giving to the child. Similarly, the fear of animals is not dependent in the case of the child on previous experience. I have in mind a young girl of seven, who has had no unpleasant experience with dogs but who has a very real and intense aversion to them simply because in walking along the street the mother, having the child's hand, involuntarily tightens her grasp when passing or approaching a dog, even though the animal may show nothing but playfulness in sniffing at their heels. This is a well recognised method of propagation of fear from mother to child. Similarly, the fear of attempting anything new. This is best shown in the frequent refusal of infants to eat anything new when added to their diet. It may be something to which the mother has a distinct aversion and she unconsciously passes on to the child this aversion in her questioning manner in offering this new article of diet to her infant.

*Wilfulness, Disobedience, Temper Tantrums and Breath Holding Spasms*, we are accustomed to associate with bad temper in the infant or growing child. As a matter of fact they are simply the emotional means which the child has at his disposal for shortening the distance of which we have already spoken, between desire and attainment, and are merely the carrying over from early infancy of that emotional disturbance which is most readily characterised by the example we have already given of the demand for satisfaction of appetite. They simply mean that the child has not yet learned to accept thwarting, and the increase in the distance between desire and attainment, which we are accustomed to observe in the so-called well trained child. Such lack of emotional control in thwarting, is constantly seen in adults. The mother who weeps or loses her temper over the failure of obedience of her child, is showing essentially the same emotional reaction as her screaming child who lies on the floor and bangs his head, when his desire is not immediately fulfilled. The father who becomes impatient and shouts at the youngster who does not immediately perform his bidding, is showing equally with the child, lack of emotional control and the failure to recognise the necessarily increasing distance between desire and attainment. This habit in the adult which we are accustomed to call impatience is essentially poor emotional control of which none of us are free. Unfortunately, due to our modern method of living and the

constant hurry of life, all adults are, in my opinion, chronically fatigued, whether that fatigue be due to actual physical effort, lack of sufficient rest, lack of diversion or financial worry. Such chronic fatigue is probably the greatest enemy of good emotional control that we have today.

It would perhaps be of some interest to give you a few concrete examples of some of these bad habits which we, as practitioners in the diseases of children, are constantly meeting.

Mrs. "C" brought her daughter "A" to me complaining that she was not able to stop the child, a school girl of eight, from biting her nails. Mrs. "C" is a highly intelligent woman of good education whose daughter attends a private school. All during the course of our conversation Mrs. "C" rubbed at her fingers or bit her nails. The nails on all ten fingers were chewed to the quick, yet the mother was unable to realise that her daughter was simply copying the mother's lack of emotional control in also biting her finger nails. A reasonably good cure was effected by having the mother wear gloves all the time until her own nail-biting habit was overcome. Similarly, Mrs. "B" brought her daughter of six complaining that the child was always day dreaming, yet the mother herself, even in the course of an office visit, was unable to carry on a connected conversation. She was constantly star gazing and in a so-called fit of abstraction. The mother herself was an excellent example of one of the characteristics of the nervous child which we mentioned, that is, the inability to carry on sustained mental or physical effort. Improvement of the child was only secured by separation from the mother. A similar form of imitation is seen in the habit of eye blinking in children. This habit is usually a direct imitation from some member of the family who is unconsciously suffering from the same habit. Relief is most easily secured by separating the child from the eye-blinking adult.

Mr. and Mrs. Mac, the latter a fairly well-educated women, brought their boy of five to the office because he stuttered. No physical cause was found for the stuttering but after an hour and a half of constant questioning and listening to answers, reducing the mother to tears and the father to apparent great shame, a story of gross marital unhappiness was evolved. The father was two years younger than the mother, earning a comparatively small salary, fatigued and financially worried, was constantly ill tempered; the mother overworked, underweight, was constantly emotional, wept when the children misbehaved or when the father, as he so frequently did, spoke crossly or unreasonably. The explanation to the parents that their maritally unhappy emotional life was the cause of their child's emotional disturbance, the sending of the mother on a holiday and providing her with help for her household, proved a speedy and apparently complete cure of the child's emotional instability, as expressed by stuttering. This is a very illuminating example of the transfer of lack of emotional control on the part of the parents to the child.

We know comparatively little of the stuff that dreams are made of or what dreams in childhood mean, the cause of night terrors or of sleep walking. These are occasionally classed as bad habits. Joan "C" was an only child living in a very emotional household. She suffered frequently from night terrors, the substance of which seemed to be the fear of being beaten. The father and mother had constant disagreements which unfortunately occasionally became physical. One such physical disagreement the child had witnessed and there is no doubt that the emotional shock played a large part in the onset and continuance of her night terrors. True, there are apparent physical causes for night terrors. We are constantly being re-

minded of them by the nightmares which we suffer after late meals or midnight biscuits and cheese. Children frequently have night terrors, which, fortunately, do not develop into permanent bad habits, and which are due simply to an over-indulgence at the supper table. Such night terrors, which are not essentially emotional in their basis, are comparatively readily overcome.

"W" was a bright emotional child who was and is, a confirmed sleep walker. No progress has been made in the relief of this complaint, due to the alcoholic and consequent emotional habits of his mother and father. I am quite sure that if emotional stability could be secured in the mother and father by removal of the alcoholic complication and the consequent discord in the family life, "W's" sleep walking would absolutely disappear and his emotional control be infinitely improved.

The most frequent complaint which we, as pædiatrists, see in children over the age of one year, is lack of appetite for which we can find no physical explanation. Such lack of appetite has practically always a very definite emotional basis in the mother. Unfortunately a great many mothers, particularly those of only children, have, through the public press, ill-advised reading, and physicians, been over educated as regards the need for certain definite food intake both as regards character and quality, in their offspring. This has led them to attempt to force in their children by persuasion, coaxing, threat or offer of reward, certain food for which the child has, at the moment, neither need nor desire. The refusal on the part of the child to take such food leads to an emotional display on the part of the mother. The child very quickly learns that such, to him, delightful emotional display, can be provoked and readily prolonged by refusing to eat his food; hence Junior gets a "kick" out of refusing to eat his dinner because mother will either get cross and threaten, offer a pleasant reward or be reduced to tears. You would be astounded to know of the number of mothers who come to a physician's office and shamefacedly admit that they can be reduced to tears and their whole day be emotionally upset because baby refused to eat his or her dinner. The answer is, of course, obvious. If we were raising a small animal such as a pup, and the animal refused to eat its food when set before it, we would take what steps we could to assure ourselves that the animal was not physically ailing, and having received such assurance, proceed to teach the animal to either take it or to go without, without any emotional display on our part. Similar measures, though they sound very unparental and cold blooded, are extremely efficacious in the treatment of this bad habit — anorexia nervosa—in children. Offering of food in a room alone where there are no other disturbances and parents with their emotional instability are out of the picture, and removing the meal if refused, usually produces a very rapid and complete cure. It is well known that such anorexia nervosa is not seen among the poor. Where there is barely sufficient food to go round the family board, lack of appetite, in the absence of physical illness, is an unknown quantity. Only where there is excess of food and excess of parental solicitude does anorexia nervosa make its appearance.

Finally, to return for a moment to those so-called auto erotic practises which we mentioned, thumb sucking, thigh rubbing, masturbation; such bad habits are essentially simple manifestations of the child's interest in self and his ability to secure emotional satisfaction immediately, from himself, without outside assistance. It is my belief that they are not of themselves practices which produce evil end results. The evil of thumb sucking is the danger of deformity of the face and mouth and only because of the danger of producing this would

I recommend steps towards its discontinuance. Because of the likelihood of such unfortunate development, some means of preventing its continuance must be instituted. Such means are several and need not be enumerated here, the point being that interference is required, not because of the bad habit but because of the severe physical consequences which follow. Masturbation and its equivalent, thigh rubbing, in infancy, does not, in my experience, produce any gross physical, moral or mental defect, nor is it, as it is so frequently considered, a sign of mental deficiency or backwardness. It is seen frequently in backward or mentally deficient children, probably because of their inability to develop outside interests and they remain dependent entirely on self for emotional satisfaction.

These wandering thoughts may seem of themselves not related to the topic of parent training. However, I have attempted to show you the course of development of the child's emotional life, its pattern of the life about him, the gradual acceptance of thwarting and the gradually increasing distance between desire and attainment in the hope of greater benefit. This gradual acceptance we expect, as being the characteristic of normal emotional adult life in our present civilisation. I have tried to point out to you that the emotional training of childhood and infancy depends entirely, not on something within the child himself, but is subject to the example of the adults who compose his emotional environment. A successful emotional training of children is not possible excepting in the presence of emotional well-trained parents, and until parents, through training and education, can secure for themselves good emotional stability, we cannot look for emotionally stable children. Hence my topic—Parent Training.

Te repeat the aphorism which I quoted early in my lecture: There is nothing which we can pass on to our children of as great value to them as good emotional control, which is far better than good physique or worldly wealth, and such good emotional control is only attained by precept and example.

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## *Increase of Tuberculosis Among Nurses*

By ANN M. FORREST, Lady Superintendent, The Queen Alexandra Sanatorium, London, Ont.

Looking over the records of the last ten years, it has been a source of considerable encouragement to those engaged in tuberculosis work, to note the steadily decreasing death rate from this disease throughout the Dominion.

This improvement may be attributed to three causes: (1) to better education in health generally, which has raised the standard of living for the very poor and the indigent; (2) to preventive measures by means of travelling and extension clinics which reach the early, and contact cases in remote districts, and (3) to increased hospital accommodation which cares for the advanced and open cases, thus removing sources of infection from the homes.

While this encouraging situation exists in the general population, it has become evident that tuberculosis is increasing rather than decreasing, among one of the valuable groups of workers in the campaign for better health—that is among the nurses.

The following figures show the increase in the number of nurses ad-

(A paper given at a meeting of District 5, Registered Nurses Association of Ontario, June 13th, 1931.)

mitted to one sanatorium in Ontario during the last ten years:

| | | | |
|---|---|---|---|
| 1921 | 5 | 1926 | 6 |
| 1922 | 3 | 1927 | 15 |
| 1923 | 4 | 1928 | 10 |
| 1924 | 4 | 1929 | 21 |
| 1925 | 6 | 1930 | 16 |

As we are all aware, good health is one of the first and most important requisites for entrance to our schools of nursing, and a high standard of health is necessary to success in our work.

Dr. J. A. Myers makes the following statement: "A nurse's breakdown from such a communicable disease as tuberculosis reflects upon her professional training and upon the practice of preventive medicine," and he adds, "Every year in this country (the United States) a good many public health nurses have the adult type of tuberculosis disease, detected only when it is in its advanced stage."

The problem of the cause and the control of tuberculosis among nurses is receiving the serious attention of the medical profession.

In 1926 a preliminary study was made by Dr. D. A. Stewart, of Manitoba Sanatorium, Ninette, and data collected from thirteen Canadian sanatoria. In March, 1930, a paper was published in the Canadian Medical Association Journal by Dr. E. L. Ross, of the Manitoba Sanatorium, Ninette, based on a study of tuberculosis in sixty nurses who had been patients in that sanatorium within the previous five years, together with facts gathered from the preliminary study of 1926.*

In June, 1930, Dr. J. A. Myers presented a paper at the convention of the American Public Health Association in Milwaukee on "The prevention of tuberculosis among nurses."

All of these papers reveal a most painstaking study of the subject and are interesting reading for nurses. I am quoting freely from all three, and wish to fully acknowledge my indebtedness to them for the facts contained in this paper.

Of the series of sixty studied in Manitoba forty broke down during training, ten developed symptoms within the first year after graduation —and it is very interesting to find that eight of the ten had remained in hospital positions; the remaining ten broke down in from three to seventeen years.

Of the sixty, fifteen had broken down before the age of twenty, and thirty-four—or more than one-half—before the age of twenty-two. It is significant, perhaps, that three-fourths of this series began training before twenty-two and some had finished before that age.

The type of disease shown was somewhat similar to the type common in childhood and it was thought that the causes were the same.

Children have little immunity, and when exposed to gross infection develop acute disease, often basal, whereas the adult type usually shows lesions in the apices.

Young nurses from average or better than average homes living under good conditions, have met with little infection and have, therefore, developed little immunity. When they meet with open cases of tuberculosis, especially if they are not protected by proper routine they are virtually in the position of little children. It must be remembered too, that previous to beginning training most of their life had been spent in school. Few had done definite work or carried much responsibility. It is not surprising that the majority of them found the work exacting, the hours long and the increased emotional strain exhausting. Hospital environment, routine, and even food is different; and there is likely to be unwise expenditure of energy even with the most careful supervision.

(*See The Canadian Nurse, June, 1930.)

There is much in these changed conditions to lower resistance, and anything which tends to lower resistance tends also to increase the danger of illness, especially of tuberculosis.

In an analysis by age periods, made a few years ago in the United States, it was found that the mortality from tuberculosis had declined 36 per cent. in the whole population over the previous decade.

The greatest decline was shown for children under five years—over 50 per cent. From five to fourteen years—about 41 per cent, and from twenty-five to forty-five years, when the hazards of life are great for both men and women, the death rate from tuberculosis had declined about 42 per cent. The young adult group alone, from fifteen to twenty-four years, had made little progress in overcoming tuberculosis; and in the age, from fifteen to nineteen the death rate for girls was 75 per cent. higher than for boys.

What the causes may be has brought forth much discussion, but whatever the causes, the situation is one which calls for serious thought, since the recruits to our profession come from young women at these very ages. We must recognise that we are dealing with a group which has the highest mortality from tuberculosis in the entire population.

A further study of tuberculosis with reference to occupations appears to indicate that the incidence among nurses is relatively higher than among women in other occupations. In a total of 1514 women treated in thirteen Canadian sanatoria, ninety-nine were nurses, a little over 6½ per cent. As many nurses were under treatment as school teachers, stenographers and university women taken together.

Dr. Myers states, "Every girl who enters the nursing profession, exactly as every girl or boy who enters the medical profession, knows that she is entering a profession of hazard," and he continues, "I am firmly convinced that nursing is a far more hazardous occupation than it should be."

Are student nurses exposed to infection while training in general hospitals; and are we doing all that we should to protect student and graduate nurses from tuberculosis?

Many hospitals have rigid rulings, to the effect that no tuberculous patient can be admitted for treatment, yet the truth is, that there are few general hospitals which do not have their tuberculous patients daily. They are admitted for other conditions, for which they are treated, without ever having their tuberculous disease suspected.

Patients come to the hospital for operative treatment, for fractures, for goitre and for chronic disease of many kinds, and among them are some undiagnosed, open cases of tuberculosis. Because of symptoms which are detected during a general examination these cases may be given a chest examination while still in hospital. They have been found to have advanced tuberculosis with cavitation and positive sputum.

It is generally stated that tuberculous people may be safely treated in general hospitals if known, and classed as tuberculous, and if the training of the nurses includes the essential measures necessary for the care of the patient and for the safety of the nurses.

Nurses should receive definite and thorough teaching about tuberculosis and about the routine for tuberculous patients, especially about the routine as to cough, and the disposal of sputum.

Tuberculous infection is carried principally in the sputum and in the droplets spread over clothing, hands, food, etc., by careless coughing and sneezing.

A cough is practically always dangerous, whatever the cause, and every cough should be covered. The best

way to cover a cough is with a paper handkerchief, held closely over the mouth and nose, and discharged at once into a paper bag and the bag and contents burned.

Apart from tuberculosis much could be done to prevent common colds and other infections of the respiratory tract if this simple rule was always observed.

What measures could be carried out by the school of nursing and the hospital for the greater safety of the student nurse?

(1) Every applicant for training should have a careful physical examination, including an x-ray of the chest, and an intracutaneous tuberculin test. There should be repeated examinations at regular intervals.

(2) Every patient admitted to the hospital should have a thorough history taken, and should have a complete physical examination made.

(3) Every general hospital should have its tuberculosis service, where these patients may be treated, thus giving better service to the community. On such a service, the student nurse can be taught the technique of the prevention of the spread of contagious disease, how to protect herself, and how to teach others the prevention of tuberculosis.

What is the nurse's own responsibility to herself and to her patients? It is to practise and teach the fundamental principles of personal hygiene.

Perhaps the very simplicity of this formula has made it seem unworthy of much emphasis, yet the practice of the five important factors of personal hygiene are, at present, basic in the treatment of tuberculosis. Rest, fresh air, sunshine, adequate diet and the sanitary disposal of body discharges, are subjects the nurse should practise herself, and teach to others if she wishes to make a real contribution to the prevention of tuberculosis among nurses and among all members of the community.

Another aspect of the problem of tuberculosis among nurses which cannot be overlooked, is their care and maintenance when active disease has developed; and their re-establishment in suitable occupations when they have recovered a measure of health. The nurse's income is rarely sufficient to permit of any substantial accumulation, but systematic investment of even small amounts, over a period of years, will give some protection for the rainy day, and a peace of mind which goes a long way towards restoring health.

The American Nurses Association has a Relief Fund which can be drawn on by those requiring it, as a loan, I believe. The report of the committee in charge of this fund in June, 1930, showed that of the nurses who had received aid since 1911 approximately 47 per cent. were suffering from tuberculosis.

In Canada we have no relief fund, and the nurse who has made no provision for illness, or whose funds become exhausted during the lengthy course of the disease, becomes a public charge.

The re-establishment of the tuberculous ex-patient is being rather inadequately dealt with at present, but several schemes are being studied and in some places practical results are being obtained, in a small way.

For the nurse the best place to achieve re-establishment is undoubtedly in special hospitals or sanatoria for the care of the tuberculous. In these institutions, gradually increasing exercise can be given, and supervision continued until the nurse is able to return to full-time duty. This would involve considerable outlay on the part of the institution for increased accommodation, etc., and where the necessary funds can be obtained is part of the problem before us. That there is a real problem can scarcely be ignored in view of the published facts.

# *Canada, Host to the American Hospital Association*

*September 29th to October 2nd, 1931*

It was Toronto's privilege to act as host for Canada, to the American Hospital Association, on the occasion of the 33rd Annual Convention, September 28th to October 2nd, 1931. Toronto has always been distinguished for graciousness of manner and true hospitality towards all visitors to that fair city. As a climax to the perfect arrangements, Dame Nature added her contribution. The weather was perfect: warm, sunny days, beautiful sunsets, and moonlit evenings. The new Automotive Building, situated in the Canadian National Exhibition grounds, is architecturally and materially pleasing to the most critical eye. It is situated on the lake front and as one stood on the wide stone entrance looking out over the green grass and gardens sponsoring tall red cannas and salvia, one felt that the setting for the day time activities was all that could be desired. The Royal York Hotel lent its beauty to the evening functions.

Registration was arranged immediately inside the Automotive Building. There was no confusion. Arrangements were made for registration as to hospitals, state or province, and city. The badges, designed by the local committee, were most attractive: a name plate on a heavy blue satin badge, weighed down by an attractive gold maple leaf bearing the crest of the American Hospital Association.

Surrounding the registration booth were post office, telephone, telegraph and information desks, also an attractive flower booth. On the balcony an excellent cafeteria was in operation. The four corners of the huge hall were built up with sound proof material and used as auditoriums. Each was named in honour of a deceased president of the Association. The balance of the floor space was given over to exhibits, professional and commercial. Large sky lights provided day light and sunshine to the exhibitors. This was an unusual and restful feature. The commercial, as well as the professional exhibits were of great educational value. In many instances the president, or other executive officers of the firms exhibiting, were present, affording one unusual opportunity to discuss equipment features, good or bad. The exhibitors gave one the impression that they were receiving equal assistance from the hospital people. Selling was not stressed, therefore, one felt quite free to linger and learn. Often one would see two or three hospital people in conference with the exhibitor on important matters relating to his product. The professional exhibits were well arranged and well supervised. Here one gathered many extracts and interesting booklets for home reading.

The programme as arranged by the Association was full and brimming over. Something for everyone in every phase of hospital work. A hospital could send every member of the staff, including the chief engineer, x-ray technician, office staff, training school staff and so on, and all could glean valuable information, saying nothing of stimulus obtained from attending such an event. No one could leave without having caught the spirit of the tremendous effort being put forth to better hospital conditions on this continent. Boards of Trustees of hospitals were unusually well represented at this meeting.

As well as providing a programme for the members, the local committee undertook to provide entertainment for visiting guests, the families and friends of the members. A delightful tea was arranged at "Deancroft," the home of Mrs. A. E. Gooderham. Lady Eaton entertained at a delight-

ful reception and a musicale in the new auditorium of the T. Eaton Company. The large hospitals in the city held open house for the members of the Association and their friends.

Following the Trustees' Section meeting, on the evening of Tuesday, September 29th, the local committee arranged a delightful supper dance at the Royal York Hotel. The annual banquet of the Association was unusually fine. We were honoured by the presence of the Honourable R. B. Bennett, Prime Minister of Canada, who brought greetings to the Association. The celebrated Toronto Mendelssohn Choir entertained the Association at this time. Those present will never forget the rendering of the National Anthems of Canada and the United States by the choir. We were spell bound.

The Nursing Section meeting, held on Thursday evening, was well attended. The subject of the symposium was "An Experiment in Co-operative Planning," introduced by Miss Ethel Johns, R.N., Director of Studies, Committee on Nursing Organisation, New York Hospital, Cornell Medical College Association, New York. Discussion was opened as follows: From the point of view of the hospital superintendent, Miss E. Muriel Anscombe, Superintendent of Jewish Hospital, St. Louis, Mo.; from the view point of a director of a School for Nursing by Miss J. I. Gunn, Reg.N., Superintendent of Nurses, Toronto General Hospital; from the Public Health point of view, by Miss E. Smellie, Reg.N., Chief Superintendent, The Victorian Order of Nurses of Canada, Ottawa, Ontario. Following this meeting the Toronto nurses entertained the visiting nurses at a delightful supper at the Royal York Hotel.

Mr. Paul H. Fesler, Superintendent, University of Minnesota Hospital, Minneapolis, Minnesota, was elected president of the American Hospital Association, succeeding Dr. Lewis A. Sexton, Superintendent, Hartford Hospital, Hartford, Conn. We are all very happy in the appointment of Dr. George F. Stephens, Superintendent, Winnipeg General Hospital, Winnipeg, Manitoba, as president elect.

*E. M. McK.*

## *The Lazaretto at Bentinck Island*

By WINNIE L. CHUTE, B.A., Reg.N.

The disease leprosy is not common in Canada, yet that it is present is evident from the fact that there are in Canada two special hospitals for the care of leprosy, one situated at Tracadie, New Brunswick, and one on Bentinck Island, British Columbia.

The incidence of leprosy in the province of New Brunswick is well known as it is part of the early history of the province. How two sailors from Levant in the year 1812 landed at Caraquet, and walked from there to Tracadie. There they received hospitality from a French family named Benoit. These two sailors are reported to have exhibited several ulcers on their bodies. Within the few years immediately following some members of the Benoit family were found suffering from leprosy which is supposed to have constituted the focus from which the disease spread to the population. It spread to such an extent that in the year 1844 the government of the province was prevailed upon to establish a lazaretto, and during the first year as many as twenty-seven lepers were segregated in that place. The changes in this lazaretto and the existing condition there at the present time under the management of the Sisters of St. Joseph have been described by a Sister of St. Martha in *The Canadian Nurse* of July, 1929. With the coming of the emigrants from the oriental and central European countries, there arose

in all parts of Canada leprosy of foreign origin. A few cases in the central and eastern provinces were cared for at Tracadie, but the greater number occurred in the west and British Columbia, and so it became necessary to establish a hospital for lepers in British Columbia.

The history of the lazaretto in British Columbia is connected with the laws which have been enacted at various times relating to this disease and with the development of the Department of National Health. A group of buildings on Darcey Island composed the first lazaretto. This island is situated in the Gulf of Georgia, about fifteen miles from Victoria City. Dr. C. B. Brown, Medical Superintendent of the present lazaretto, in writing about this first building, states: "There was no organisation of any account. The buildings were of the shack nature. Periodically a tugboat with supplies and a doctor went out to see them. They had a signal they hoisted if they specially needed anyone in the intervals. Finally in 1906 all lepers became the care of the Dominion Government. Arrangements were made to repatriate them. They, fourteen in number, being sent to China to the care of a leper mission. This was successfully carried out."

Following this, suitable buildings were erected on Darcey Island; that these buildings were erected on two islands, on one a residence for the caretakers and on the other a two-room cottage for the patients may be taken as an evidence of the attitude taken at that time towards the disease, as we find that later this idea of complete segregation was not carried out. The supervision of these buildings was carried out by the medical officers at the quarantine station at William Head. In 1915 the cottage for the patients was abandoned and others erected on the same island as the caretaker's residence. At this time a new caretaker was appointed, whose wife being a graduate nurse, was engaged to care for the patients. To again quote Dr. C. B. Brown, "From this time on the patients have been treated with the most advanced treatment known to medicine for this disease. Added to this they get the most careful and sympathetic nursing. They have regular medical attention. Their quarters have been simple but suited to the needs." Following the organisation of the present Dominion Department of National Health and certain investigation made by that department, it was felt that Darcey Island was unsuitable because of its isolation. Bentinck Island, situated about three miles from William Head and very accessible for supplies and medical attention, was chosen as the site of the new lazaretto. The patients were moved in 1924, to this, the present site of the lazaretto.

If we visited this island today, we might be accompanied from the quarantine station at William Head by Dr. C. B. Brown, a specialist in this disease and one who takes the keenest interest in the patients. Dr. Brown is medical superintendent of the lazaretto as well as quarantine officer at William Head. We would land at a small but well built landing wharf.

Mrs. Williamson, a graduate nurse who co-operates with Dr. Brown and his co-workers in the care of the lepers, would be found in one of the two comfortable residences, provided for the staff of workers who care for these patients. These residences are made modern with electric lights and running water furnished from a central Delco plant. As we are interested in the patients, we proceed at once to their living quarters. At the present time all the patients are Chinese. Each patient has a two-roomed cottage with a verandah facing south, furnished simply, but with sufficient equipment for comfort, with a plot of ground for a garden, a chicken house and a run. If the patient's physical condition is fit each one is encouraged to do his own work. Two cottages, larger than

the others, with running water and bath rooms are for the possible white patients; two such, both Russians, one a Jew and one a Doukhobor, have in the past occupied these cottages. Another cottage may be used as a hospital for a bed patient and one is reserved to be used as detention quarters. In the care given the patients, hygienic living conditions and a diet, high in fat, vitamines and mineral salts is stressed. Those requiring drugs are treated with moogrol and alepol derivatives (ethyl esters of the fatty acid) of chaulmoogia oil; these are administered by injection, also the whole oil is given by capsule. Each new patient received into the lazaretto is examined by Dr. Brown, who makes photographs of the affected parts of the body. These photographs become part of the case records used in lectures on the disease. Treatment with moogrol and alepol is started, but if these drugs are not effectual, others are used. Mild disinfectants and ointments are used to cleanse and treat the open sores.

Our visit to such a lazaretto would reveal several surprising things to us; we would learn that many patients show no outward evidence of the disease and also that the disease is not extremely infectious. We would see patients illustrating the two forms which the disease takes. Here a patient suddenly develops blisters on an arm or leg, the blisters go on to ulcerative sores, and after months the bone becomes involved: on the removal of the diseased bone the lesion heals quickly. In another it takes the nodular form with trophic ulcers: this is the most horrible form. On seeing such a patient we understand why the attending doctor states that this type calls for heroic nursing care. Again, there is the patient who is blind as a result of this disease and nothing has been discovered yet to prevent this destruction of the visual apparatus.

We learn also that leprosy is not infectious, that one case contracts the disease from another, but it is the least infectious of all the diseases. The use of ordinary medical and surgical technique is an ample safeguard against the disease. The Leprosy Act states that all persons afflicted with the disease may be confined in a lazaretto unless they are non-infectious and not a menace to the public health.

The writer of this article desires to acknowledge and to express appreciation to the following persons for the information used in this article: Dr. J. D. Page, of the Division of Quarantine and Immigrant Medical Service, Department of Pensions and National Health, Ottawa; Dr. C. B. Brown, Medical Superintendent, and Mrs. B. M. Williamson, nurse in charge, Lazaretto, Bentinck Island, B.C.

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## TRIBUTE TO A NURSING SISTER

The announcement of the death of Mrs. (Dr.) A. Greenaway, of Edmonton, was received with deep regret, especially by Alumnae members of the School of Nursing, Toronto Western Hospital, and former members of the nursing staff of No. 4 Canadian General Hospital, Canadian Army Medical Corps.

Mrs. Greenaway was formerly Agnes Huston and graduated from The Toronto Western Hospital in 1913. Miss A. J. Hartley, Matron-in-Chief, Department of Pensions and National Health, pays the following tribute to the late Mrs. Greenaway:

"It was with deep regret I heard of the death of Mrs. Greenaway. She was an outstanding Military Nurse during the late war, serving in England, France, Malta, Gallipoli and Salonica from 1915-1919 with No. 4 Canadian General Hospital, University of Toronto Unit, receiving Decoration R.R.C. She was an ideal nurse, a noble Christian woman and beloved by all."

# Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss MILDRED REID, 10 Elenora Apts., Winnipeg, Man.

## *Suggested Curriculum for Schools of Nursing in Canada*

SECTION III.

In the October issue of *The Canadian Nurse* the content of the preliminary and junior terms were published. The second or intermediate year subjects are presented in the current issue, and it is hoped that superintendents and instructors will criticise these freely.

THEORETICAL COURSE OF STUDY
(Continued)

Second Year Subjects

| | Hours |
|---|---|
| Pædiatrics and Pædiatric Nursing Clinics | 12 - 15 |
| Medical Lectures | 15 |
| Diseases of the Skin | 3 |
| Surgical Lectures | 12 |
| Gynæcology | 4 |
| Orthopædics | 3 - 4 |
| Operating Room Technique | 8 |
| Anaesthesia | 2 |
| Eye, Ear, Nose and Throat | 8 |
| Oral Hygiene | 1 - 2 |
| Communicable Diseases | 8 |
| Tuberculosis | 3 |
| Social Diseases | 2 - 3 |
| | 81 - 87 |

*Note*: In hospitals where there is a good pædiatric and communicable diseases department, it enhances the value of the course to have the supervisor of these departments (rather than the practical instructor) give six to eight periods in the nursing care of her special branch. This, of course, would increase the number of lectures, either in the first year or early in the second, but the periods allowed for these subjects (at present included in the Practical Procedures) could be slightly reduced. In some institutions these two courses follow immediately after the Advanced Procedures in the first year. In the case of the communicable diseases, the detail of diet, demonstrations of technique and isolation precautions, which are not usually included, would be covered by a physician in the regular communicable diseases lectures. It also prepares the nurse for practical experience in the department, should she receive it early in her course.

The Pediatric Nursing course, if given apart from the Practical Nursing course, should include demonstrations of all important procedures common in a pædiatric department and also the special points in feeding and routine care of infants and young children. If the class can be divided into groups and clinics given on the ward it has the added value of stimulating interest.

Commencing classes during the first week of September for second year students, this would mean three class periods weekly for nine weeks and two periods weekly for the remainder of the session until the end of May (allowing two weeks without lectures during Christmas and New Year). Where classes go on until the end of June, it would mean practically two hours weekly during the en-

(Prepared by a Special Committee of the Nursing Education Section, Canadian Nurses Association, of which Miss G. M. Fairley is convener.)

tire session. This does not make any time allowance for cancelled classes, and as this problem is a common one in most hospitals it sometimes means crowding towards the end of the class year unless the instructor, or whoever is responsible for the arrangement of lectures and lecturers, is alert in making the necessary adjustments. Sometimes it is possible to have one or two substitute lectures ready (if due notice of a cancelled class is given) and thus save wasting a class period. For instance the lectures on anaesthesia, or oral hygiene or one of the operating room technique series can fairly easily be introduced without breaking into the continuity of the course.

*Practical Experience*

By the commencement of the second year, having gained considerable experience during the first night duty term, the student has usually developed greater poise and is ready for still further responsibilities. Also she is ready for some of the special department training and can be posted for such experience as diet kitchen, communicable diseases, pediatric service, and later (about midway in her training) operating room and obstetrics. If possible at all, operating room service should precede obstetrics. The size of the hospital and also the departments within the hospital vary so much that where in one institution there may be plenty of experience in obstetrics and case room, in another it may be difficult for all students to see the necessary number of cases. However, it is important to plan the practical course so that experience in the special departments will, as far as possible, be complete in about two and one-half years, so that during the last six months the student can apply the experience thus gained and also have an opportunity of developing executive ability.

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## *Comments on Suggested Curriculum for Schools of Nursing*

(Second Year Subjects)

It has already been stated that the Suggested Standard Curriculum is in no way an arbitrary outline or one that can be rigidly adhered to in either large or small schools of nursing, but merely a minimum standard for the guidance of those who are interested in and responsible for the education of student nurses.

In adapting this curriculum to suit the existing conditions and the problems which present themselves in every school, certain definite principles should, however, be borne in mind, an accepted one being that the theoretical instruction in any subject should precede or run concurrently with the practical experience. To send a student to any department for practical experience without this preparation is nothing short of disastrous. One might almost as well eat the meal and consider the preparation of it afterwards. If nurses are to get practical nursing experience in obstetrics "mid-way in the course," the lectures and classes in obstetrics must precede or accompany this experience. For this reason too many consider that medicine and surgery should be included in the "first year" subjects, leaving a space for lectures in mental hygiene and at least the elementary principles of public health nursing and social service to be given early in the second year. While it is recognised that practical experience in a psychopathic department is not always, and indeed is seldom feasible, a few well-thought-out, carefully-

delivered lectures in mental hygiene should not be omitted from any school curriculum and should be given quite early in the course. Some knowledge of the intricacies of the nervous system, the close relationship of the mental and physical make-up of an individual, and of the power of suggestion is an almost indispensible asset to the nurse and should enable her to be a much more understanding assistant to the patient and, indeed, to those who are not patients but with whom she comes in daily contact.

The idea of teaching public health in the first or second year of the course is to many a fairly new thought, but is a sound one. Do not all authorities recognise today the importance of preventive medicine? Can we fail to recommend that this be taught as a basic principle to those who are to be pre-eminently health teachers, irrespective of the capacity in which they serve? Such instruction is also necessary in order that students may be alive to the immediate opportunities that are theirs and have a better understanding of some of the social problems affecting those with whom they have to deal.

Advanced Ethics may with advantage be introduced into the intermediate year, and some of the principles and problems of administration included. It would seem that such an important subject cannot be taught in a brief course of lectures given during the preliminary term. Should not these guiding principles be kept before the students, and in larger schools many directors find this opportunity to maintain contact with their students a valuable one?

Such subjects as dermatology may be regarded as special and be dealt with in the third year, students having learnt in the study of communicable diseases the necessity of dealing promptly and discreetly with all "rashes" and, for purposes other than diagnosis, even to distinguish between the more common ones of an infectious nature. Here the desirability, when possible, of using bedside instruction is obvious. When this is not feasible, graphic charts, etc., will be found a valuable substitute.

May I suggest that schools, large and small, feel the benefit of affiliation for certain special subjects? Here students have the advantage of contact with and teaching by those who are experts in this particular phase of the work. Such subjects as pædiatric nursing and communicable diseases are possibly better taught in this way. In dealing with the former, special attention should be given to infant feeding and not less than 56 hours devoted to the preparation of formulæ.

It is presumed that it is the intention to include with this suggested curriculum a list of text books recommended for use in the study of various subjects and of those that are considered suitable for the nucleus of a reference library, and some information regarding slides, charts, etc., would undoubtedly be welcomed.

The importance of bedside clinics has already been emphasized and much of the instruction now given in the class room might well be carried to the ward, or arrangements made for patients to be the actual subject of discussion. With a little explanation and tactful arrangement this can be effected without any violation of their feelings and rights. When suggested it will be found that doctors, too, welcome this method of teaching as compared with a more mechanical, and frequently monotonous, repetition of facts in the class room.

The ever-present problem of caring for the patient of today and tomorrow has also to be considered: those who are faithful to their responsibilities and the conduct of a training school must do justice to both. To relieve nurses for the attendance of classes and not to let the patient suffer, or the student become harassed and over-burdened, taxes the ingenuity of most managements. Various suggestions are offered, and in some of the larger schools it has been found

more satisfactory to divide a class into groups, definitely relieving nurses from a certain number of hours of ward duty and giving them instruction in more concentrated form. Such an arrangement, however, has its drawbacks, including the repetition of lectures, which is often impossible.

In schools where one or possibly two persons are responsible for the conduct of the school and instruction of students, such an outline may seem alarming, but this condition should not now exist; nursing education is too important and complicated a performance to be combined with other engrossing duties or to be delegated to those who possibly lack adequate preparation. Careful analysis will show that this Suggested Curriculum includes nothing that can be safely eliminated. The subjects suggested for the second year will prove to be divided into the study of the more advanced branches of medicine and surgery as they concern the nurse, and without this knowledge her education cannot be considered complete.

*K. W. E.*

**Note:** Readers may note a similarity between the foregoing comment on the third section of the Suggested Curriculum and that published in the October number relative to the second section. As the nurses who by special request contributed comment on these two sections had no opportunity of learning the opinion of each other, it is deemed advisable to publish the foregoing, although opinion expressed coincides with that published in the preceding issue.

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## *The Final Armistice*

Christ of the glowing heart and golden speech,
Drawn by the charm divine of Thy sweet soul,
The nations tend unto that far-off goal
Whereof the sages dream, the prophets preach.
We shall not always fail; we yet shall reach
Through toil and time that shining table-land
To which Thou beckonest with wounded hand.
For evermore Thy goodness doth beseech
A warring world to lay its weapons down.
So shall we rest and songs of plenty drown
The wail of hunger: and our bitter tears,
Streaming unstanched through all the dreadful years,
And freely flowing still, shall yet be dried,
When Thou art King, who once wast crucified.

—*Frank B. Cowgill.*

# Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
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## *Treatment of Empyema*

By J. A. CAMPBELL, M.D., St. Thomas, Ont.

A discussion on the treatment of acute empyema requires, first of all, reference to the physiology of respiration. In a normal healthy adult the vital capacity—that is—the maximum amount of air that can be expired after a full inspiration, equals about 230 cubic inches. During ordinary quiet inspiration the amount of air inhaled, the so called tidal air, equals about 30 cubic inches or about one-eighth of the maximum vital capacity.

In the case of the patient with a pleural effusion, although the vital capacity is diminished in proportion to the size of the effusion, he is able to breathe quite comfortably as long as he is at rest provided the effusion is not large enough to prevent the inhalation of 30 cubic inches of air during each inspiration, but as soon as he begins to exercise and the 30 cubic inches of air is not sufficient to provide for his increased need of oxygen he becomes short of breath.

Further, as a result of the experimental work of Graham and Bell, and of observations made in military hospitals during the 1917 and 1918 epidemics, it has been demonstrated that the mediastinum cannot be considered to be a structure dividing the chest into two cavities entirely independent of each other in their pressure relationship: that anything injected into or accumulating in the pleura of one side affects the intrapleural pressure on the other side to an equal degree and that except where the pressure on one side is markedly increased, we must consider the chest as a single cavity and not as two separate cavities with an effective barrier between them. As long as we are dealing with a pleural effusion in a closed chest it is not a matter of vital importance, whether the mediastinum imposes an effective barrier between the two sides of the chest or not. As long as there is sufficient space left in the thorax of the patient to inhale 30 cubic inches of air every time he breathes it is not important whether he inhales it into one lung or two. But as soon as the closed cavity is opened it then becomes a question of utmost importance, as it is possible by a large opening to produce a condition in which all the air enters the pleural cavity, and very little or none enters the lung, causing a sudden asphyxia, and, in a patient who is very ill and labouring under respiratory difficulties already as heavy as he can bear may turn the scale against him.

The dangers of open drainage apply only to cases in which there are no adhesions. In those patients in whom the empyema is sealed off from the rest of the thoracic cavity by dense adhesions between the visceral and parietal layers of the pleura, thus binding the lung to the chest wall and stabilizing the mediastinum, it is a matter of little importance as far as respiration is concerned whether the cavity is closed or open or whether it is filled with pus or atmospheric

air. It is, therefore, necessary to distinguish early between the two classes of empyema, those in which the pus is free in the cavity and those in which it is shut off by dense adhesions.

Now, the formation of adhesions is entirely a matter of time. In ordinary lobar pneumonia an empyema is usually a comparatively late manifestation. It develops gradually as the pneumonia begins to subside and by the time it is diagnosed it is usually cut off entirely from the rest of the thorax by the formation of dense adhesions. On the other hand, in the case of streptococcal empyema associated with a bronchopneumonia the condition is just the reverse. The invasion of the pleura by the infective organism takes place quite early in the illness: an empyema develops almost at the same time as the bronchopneumonic changes in the lungs and may appear so rapidly as to constitute almost a primary manifestation of the illness. In such cases there has been no time for adhesions to form. The pus is free in the thorax. Such cases which are common in children are always severe, and the patient, especially if a young child, is usually desperately ill, and any operative procedure, especially if it involves even a temporary open pneumothorax, is extremely dangerous. If it is necessary to apply drainage to a case of this type, aspiration should be done to tide the patient over this critical period, giving time for adhesions to form and the general condition improve.

Aspiration itself is a somewhat painful and distressing operation, especially in a very sick and possibly frightened child. In such cases the introduction of a self-retaining catheter attached to some suction apparatus is a much better form of treatment. The introduction of a catheter is not difficult, the shock is less and the dangers attached to an open pneumothorax are avoided. It, therefore, may be employed early, even in the streptococcal cases in which no adhesions may be expected to have formed.

Another important point in the treatment of empyema is the necessity of sterilising the cavity at the earliest possible moment and preventing any secondary infection through the opening in the chest wall. Prolonged inflammation of the pleura, whether it results from the primary infecting organism or from some secondary infection, may result in a chronic empyema with all the attendant risks to health and life. In order to sterilise an empyema cavity frequent irrigations with a most suitable antiseptic, as Dakin's Solution, is of great assistance. It is non-toxic and can be freely used, and it has the action of softening the large masses of exudate which makes efficient drainage a difficult matter.

In conclusion, in the treatment of empyema:

(1) Operative procedure should be such as to involve the minimum of time and the minimum of shock.

(2) If it is necessary to employ open drainage, it should not be employed until it is reasonably certain that the empyema cavity is well walled off by adhesions.

(3) It is necessary to distinguish between pneumococcal empyema in which adhesions are usually formed by the time the empyema has been diagnosed and streptococcal empyema where adhesions are not usually formed till later.

(4) In order to minimise the dangers of secondary infection the opening in the chest should be no larger than necessary to admit the drainage tube and should fit closely around the tube when in position.

(5) The cavity should be sterilised early by frequent irrigations with Dakin's Solution.

(6) The lung should be encouraged to expand by insuring a negative pressure in the pleural cavity throughout drainage.

(7) Convalescence should be assisted by plenty of nourishing food and the patient kept in the open.

To meet these requirements the employment of the closed continuous suction drainage is the most advantageous as:

(1) The introduction of the catheter is easy and entails very little shock.

(2) Anaesthesia is brief and with the exception of the child may be done under local.

(3) The tube causes little pain.

(4) Nursing is easier and cleaner.

(5) The risk of secondary infection is very much diminished.

(6) The wound closes earlier.

(7) Re-expansion of the lung is more rapid and complete.

## THE LEAGUE OF NATIONS STUDIES CHILD MORTALITY

The Child Welfare Committee of the League of Nations has just released the report of the studies of the causes of infant mortality in Europe and Latin America made by the Health organisation of the League of Nations, and carried out in twenty-nine urban and rural districts of seven countries: Austria, France, Germany, Great Britain, Italy, Netherlands, and Norway.

The inquiry drew attention to the fact that stillbirths and deaths of infants in the first few days of life have not decreased—whereas there has been a marked falling off in infant deaths occurring later in infancy—and due to such causes as digestive disturbances, infectious diseases and diseases of the respiratory tract. The control of these diseases has been brought about in districts in which the economic conditions are favourable, the intellectual level of the population high, and where efforts have been made to improve public health and medical practice. However, these particular districts have not brought about any reduction in the still-birth rate, the number of premature births, or the number of infants dying in the first week of life.

The committee considered that these problems call for further research by obstetricians and pediatricians. The cause, prevention and treatment of respiratory diseases raised still more problems to be settled. The committee felt that the inadequacy of the training of mothers, in infant and maternal welfare, and the insufficient number of trained visiting nurses and social workers should be included among the social causes of infant mortality.

A study of our vital statistics reveals that a reduction in infant deaths has been brought about in Canada. The progress in the last ten years is well marked. The infant death rate in 1920 was 102 per thousand live births and in 1930, 89.3 per thousand. This reduction has been in diseases of the digestive system. Public Health authorities consider this reduction due to our newer knowledge of the feeding of infants, to better hygienic care of the infant, to safer milk and water supply and to the educational emphasis on breast feeding. The reduction of losses that has been made has been limited practically to after one month of life. Canada still loses annually 21,000 to 22,000 infants, half of this number in the first month of life, and a third of the total deaths in the first week of life. It is noteworthy that in 1930, four causes present at birth, namely premature birth, injury at birth, congenital debility and congenital malformations account for nearly 43% of the total deaths. Add to this loss the loss in infant lives through still-births, which in 1930 amounted to 3.1% of live births or 7695 infant lives, and one is appalled to find the total deaths in these groups almost equals that of deaths from all causes in the first year of life.

To sum up, while there has been a marked reduction in the number of infant deaths under one year—public health officials state that there are still unnecessary deaths in this group and especially from respiratory diseases. There is need also in Canada for further research into the causes and prevention of still-births, premature births, and infant deaths under one month of age. Obstetricians have brought to our attention the fact that many maternal and infant lives could be saved by the strengthening of each link in the chain of obstetric supervision, an increased watchfulness over all stages of pregnancy, labour, and post-partum care.

More popular education of the mother and of the public in the necessity for adequate maternal and child care seems to be required in Canada as well as in Europe.

The Canadian Council on Child and Family Welfare, through the financial assistance of the Canadian Life Insurance Officers' Association, have prepared for free distribution to any mother, anywhere, simple scientific information dealing with her care during the nine months of pregnancy and in the post-natal period and with the care of the child in its first year of life. The Council wishes to make the service known to every expectant mother in Canada. The distribution is arranged through the Provincial Department of Health in each province, and through application to the Canadian Council on Child and Family Welfare, Council House, Ottawa, Ont.

# Department of Public Health Nursing

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## *The American Public Health Association*

By MARGARET L. MOAG, Chairman, Public Health Section, Canadian Nurses Association

The American Public Health Association held its Sixtieth Annual Meeting at the Windsor Hotel, Montreal, September 14th to 17th, 1931. It was one of the most important gatherings of medical men held during the year, and leaders in movements to improve the standards of public health were present from all quarters; from Cuba, Mexico, England, the United States, and every part of our Dominion, since health workers regard their problems in a truly international way. The great scope of their activities was to be seen in the programme of sections, which included contributions ranging from the laboratory group endeavouring to find the causes of disease, to the epidemiologist, who, in the field, attempts to solve the problems connected with the spread of disease. Leaders in the medical, public health nursing, dental, nutritional and mental health fields came together to discuss the aims and general trends of health work.

Of particular interest to public health nurses were the joint sessions, where nurses and medical men met to discuss their relationships and efforts for the betterment of the health of mankind. Mental hygiene and its place in the programme for community health was discussed from various angles at the first of these joint sessions, Dr. C. W. Hincks, Director of the Canadian National Committee for Mental Hygiene, presiding. That no well balanced public health programme should be considered complete without mental hygiene was emphasized in the different papers presented at this session. Modern concepts were outlined, the necessity for a four-fold field of study in child guidance, and the value of adhering to the rules of individual case procedure in drawing up a mental hygiene programme for any community were set forth. Miss K. Tucker, General Director of the N.O.P.H.N., emphasized the importance of correlation with the established work of the public health nurse, while Miss Effie Taylor, Professor of Nursing at Yale University, reiterated the necessity of mental hygiene training for every nurse. That the public health nurse has a definite responsibility in influencing parents and the public regarding the importance of mental hygiene, through her wide community contacts, was the subject of the discussions that followed. It seemed reasonable to suppose that all public health nurses should recognise their responsibilities and opportunities, and improve their own knowledge and ability in this particular field.

Two joint sessions on Child Hygiene were held, where papers and discussions on the "Aim and Practical Application of Professional Services," and the "Education and Training of Personnel for Child Health Work," might well have provided a programme for the entire week. The undesirability of appointing either physicians or nurses without special preparation for this important field was pointed out, also the difficulties in the cost of training to universities and to larger health organisations financed by community funds, who find it necessary to operate training centres. Dr. Ferrel, of the Rockefeller Foundation, noted that rigid eligibility requirements as to age and academic qualifications cannot yet be enforced, but progress in laying a foundation for suitable standards in the future were being made.

Emphasis of the value of providing the undergraduate nurse with a certain amount of information regarding the structural, physiological and mental development of the normal child was made by Miss C. H. Peck, Director of the Infant Welfare Society, Minneapolis. This, she suggested, might be provided through three months' affiliation with a public health nursing organisation where well supervised field work prevailed. Miss Marion Howell, Director of the School of Applied Social Sciences, Western Reserve University, Cleveland, drew attention to the fact that all university courses are new and that much basic knowledge which should have been given in the parent training school had, of necessity, to be taught in post-graduate courses. The lack of well selected and properly trained personnel is evident in all public health nursing organisations, and the need for worthy teachers in universities who can inspire students was stressed by the speaker. The needs of the future were summarized to include increased financial support, well qualified personnel, and increased professional support from our nursing group, who can do much to interest lay members.

The value and difficulties of staff education was emphasized by Miss Elizabeth Fox, Director of the Visiting Nurses Association of New Haven, as well as other speakers, but the expense of the organisation has, of necessity, to be a matter of consideration.

The Administration of a Nursing Service in a large city was presented by Miss Esther Beith, Executive Director of the Child Welfare Association of Montreal, who stated that she saw no possibility of an adequate sickness service applicable to the class who most need it being provided, except through some form of health insurance.

Papers were also presented by Dr. Phair, Director of the Division of Child Hygiene, Provincial Department of Health, Ontario, on the work of the rural field, while that of the medium city was discussed by Dr. Ruhland, Committee of Health, Syracuse, New York, and Miss E. Cryderman, District Supervisor, Victorian Order of Nurses, and others.

To have listened to Miss Agnes Martin's paper on "What the Chief Nurse Expects of Her Health Officer," wherein she outlined the difficulties confronting the chief nurse when her staff were appointed primarily for their "good looks," or through political favour, the need for closer co-operation between the health officer and the chief nurse, and to have heard the discussion that followed among the large group of health officers who were present, made one feel that there need be no fear for the future.

Steps that have been taken by a special committee, selected to study the effects of pre-natal care on infant and maternal mortality, and some of the difficulties that have been encountered, were outlined by Dr. C. E. A. Winslow, Yale University. Further facts and figures were given by Dr. Julius Levy, State Department of Health, New York, in a report to the committee that has been investigating infant and maternal mortality during the past two years.

An interesting paper on the Development of Pre-natal Care in the Province of Quebec was presented by Miss Alice Ahern, Assistant Superintendent of Nursing, Metropolitan Life Insurance Company, Ottawa.

Handicaps under which Public Health Nursing Education labours, and means by which they may be overcome, were discussed by Miss Lillian Hudson, Professor of Nursing at Columbia University. The advisability of directing young women of high capacity to large schools of nursing, and better preparation of the student for public health work was urged, also the need at present for staff education, extension courses, and institutes for those already in the field.

The sessions on Health Education were full of interest to those engaged

in school work. A summary of her methods in teaching health matters was outlined by Miss Creech, Cleveland Heights High School, where the teaching of health is a required subject for all girls throughout their junior year. Here personal hygiene, home nursing, and infant care are taught and demonstrated, and antenatal and sex instruction are diplomatically handled. In this school, health has gained a fixed and respected place in the curriculum. Other speakers pointed out the fact that health education is health training, and that through the early establishment of health habits a recognition of community and social health and their own relationship to it would be cultivated in the minds of students, the ultimate object being the preparation of young men and women to rightly meet work, love and friendship.

To those who have the responsibility of keeping the public informed and interested, the sessions on Public Health Education were fascinating. The value of radio broadcasting, motion pictures, the press, health exhibits, club addresses were demonstrated through numerous papers and addresses, while lively discussions were stimulated through the personality of Mr. E. G. Routzahn, Director of the Surveys and Exhibits Department, Russell Sage Foundation. More than one speaker advanced the idea that if one put it directly up to men how health service definitely meant saving a measurable number of lives there would be no difficulty in obtaining finances to carry on the work. The personal factor was emphasized by Miss E. A. Russell, Director of Public Health Nurses, Winnipeg, who paid tribute to the work of women's organisations in arousing public health interest in Manitoba. Dr. H. Vaughn, Health Commissioner of Detroit, showed the value of charts of districts, which enabled health workers of large cities in pointing out the necessity of funds to the aldermen of such districts, while Miss Stevens, Director of the Public Health Nursing Association, of Pittsburgh, described the publicity methods used to put over a community chest drive, emphasizing the value of giving honest facts without mawkish sentimentality.

It was evident that all members of the A.P.H.A. would seem to be agreed that all that is required of diet is that it should be "well balanced," the depth of meaning lying behind those words being realised to varying degrees by different speakers at the sessions on "Food, Nutrition and Drugs."

The British delegation, who presented papers dealing with different aspects of the administration of public health in England, reported the appointment of a Nutritional Committee to the Ministry of Health.

The usual breakfast, luncheon, and dinner sessions were arranged, and during the public health nurses' luncheon, Miss Margaret L. Moag presented the greetings of the Canadian Nurses Association and welcomed the delegates on behalf of the Public Health Section.

All who attended the meeting voiced their deep appreciation of the work of the Hospitality and Entertainment Committee, under the chairmanship of Dr. Grant Fleming. Excursions to county health units were arranged, also a charming dinner on the opening night, when Hon. Athanase David, Provincial Secretary of the Province of Quebec, and other speakers welcomed the delegates.

The garden party on the mountain the last day was particularly enjoyable; the day was perfect, Beloeil and St. Hilaire mountains were very clear in the distance, and the city and lordly river presented a view from the summit that one would always remember. As one of the delegates remarked, "It was a very fitting ending to a very delightful and stimulating meeting."

## *The Victorian Order Exhibit at the A.P.H.A.*

The Victorian Order of Nurses for Canada was fortunate in being able to obtain space for a small exhibit at the American Public Health Association meeting in Montreal in September. By means of this exhibit the Victorian Order of Nurses attempted to convey a twofold message: first, that the Victorian Order of Nurses is a *national* visiting nursing organisation; second, a brief statement of the type of work in which the organisation is engaged.

The central part of the exhibit was a Davis bulletin machine, which changed cards containing pictures and captions. Flanking the machine, and an integral part of the background, were two panels with a small amount of wording on each.

The whole was supported on a flight of three steps on whose faces was printed a brief resumé of the work of the Order.

In the foreground was a life-sized coloured cut-out figure of a nurse holding a receptacle for Victorian Order booklets.

The exhibit, carried out in shades of blue and yellow and with a slightly modernistic accent, presented a pleasing and dignified appearance and elicited a considerable amount of favourable comment.

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On Monday, September 14th, Miss Elizabeth Smellie entertained at a very delightful tea in the Blue Room of the Windsor Hotel, Montreal, in honour of some of the delegates attending the sessions of the American Public Health Association meeting.

Assisting Miss Smellie in receiving the guests were Mrs. H. S. Birkett of Montreal and the Right Honourable George P. Graham, LL.D., President of the Victorian Order of Nurses for Canada.

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## PUBLIC HEALTH NEWS

Nurses in Canada will welcome the return of Miss Edna Moore, who for the past two years has been associated with the National Organisation of Public Health Nursing in United States as Assistant Director in charge of the N.O.P.H.N. joint project with the American Social Hygiene Association.

Miss Moore has been appointed Director of Public Health Nursing of the Division of Child Hygiene of the Department of Health, for Ontario. She will return to Toronto for December 1st. *Public Health Nursing* (October, 1931), announcing Miss Moore's retirement from the N.O.P.H.N., states in part: "While we rejoice with Ontario and with Miss Moore in the opportunities that lie ahead, we are keenly conscious of the loss which we are sustaining. Coming, two years ago, into a new programme in what is perhaps the most difficult phase of public health nursing to explain to nurses and the public, Miss Moore has won signal success. She has travelled from Montana to Louisiana, from New England to the South Atlantic States, giving Social Hygiene Institutes. Wherever she has gone, the response has been enthusiastic, and letters of appreciation have poured into headquarters.

"Not only the country at large but also the staffs of the N.O.P.H.N. and the A.S.H.A. will miss the loyal, effective and hearty comradeship of Miss Moore. Canada gains what we lose. Added to our best wishes for future success to Miss Moore and to the Province of Ontario is our assurance that a new understanding and a new friendship transcending all boundaries will result between American and Canadian health workers through Miss Moore's unique contribution to public health."

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Miss Mary Lambie has been appointed Director, Division of Nursing, for New Zealand. She succeeds Miss Bicknell, A.R.R.C., who retired some time ago.

Miss Lambie is well known to many in Canada, as several years ago she was a student at the Department of Public Health Nursing, University of Toronto. On her return to New Zealand she became Instructor in Public Health Nursing for the Post-Graduate Diploma issued by the Victoria University and the Department of Health, a position which she filled admirably until her recent appointment.

Miss Lambie is a graduate of Christchurch Hospital and had the Certificate of Midwife and the Karitan Certificate in Child Welfare. Her friends in Canada are delighted to learn of Miss Lambie's promotion to chief nurse in New Zealand and extend their best wishes for her future success.

# *Reports of Annual Meetings*

## NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES

The 1931 annual meeting of the New Brunswick Association of Registered Nurses was held in St. Andrew's Church Hall, Fredericton, September 16th and 17th. From the standpoint of number in attendance and interest displayed, the meeting was a successful one. At the opening session, Mayor Clarke gave an address of welcome, to which the President suitably replied. The President's address was most timely, anticipating the arrival of the Report of the Survey on Nursing Education in Canada, and impressing on the members the need for study of its content. The report submitted by the Secretary, Treasurer, and Registrar showed an increase in membership of 71, a bank balance of $548.15, a total registration to date of 871 nurses. Registration examinations are held twice yearly, on the first Wednesday and Thursday of May and November, at provincial points alternating with Saint John. The report from the convener of the Nursing Education Section told of conferences with directors of Vocational Schools and the need for establishing the exact meaning of the word "equivalent" in reference to the educational entrance requirement for prospective pupils for provincial schools of nursing. The Public Health Section reported the addition of two members to the Section: Miss Ada Burns, Chairman of Publications and Exhibits, and Mrs. C. VanDorrser, Chairman of Educational sub-committee. A Child Welfare nurse was appointed recently at Shediac, another Victorian Order nurse was added to the Fredericton staff, and Victorian Order of Nurses services begun at Edmunston and Newcastle. The Private Duty Section had no definite changes to report. No organised relief was necessary for unemployment among nurses, although a number are unemployed. The Constitution and By-Laws Committee reported briefly on the strenuous work in connection with the attempt to secure amendments to the Registration Act, and the futility of the effort. The convener of "The Canadian Nurse" reported reorganisation of the work in connection with the affairs of the magazine; New Brunswick has only 70 subscribers. Miss Kathleen Lawson, convener of the Provincial Committee of Registries, reported a meeting of the committee and the resignation of Miss H. S. Dykeman as Public Health representative on this Committee. Two very excellent addresses were heard at the afternoon session, one given by Dr. G. Clowes Van Wart, on "Educational Standards—What Eventually These Should Mean," and one on "Problems of the Present Day for the Private Duty Nurse," by Miss Mabel McMullin. At the close of the afternoon session, the delegates were delightfully entertained at the home of Mrs. C. D. Richards, wife of the Premier. An enjoyable social tea hour was spent. At 8 p.m. the delegates were guests of the Fredericton Chapter of Registered Nurses at a reception and bridge held in the reception rooms of the Victoria Hospital, where a very pleasant evening was spent. On Thursday, reports were received from the four local chapters: Saint John, St. Stephen, Fredericton and Moncton. The reports showed that regular meetings were held, increased attendance, and activities increasing along educational, social and philanthropic lines. Miss Murdoch reported verbally on the progress of arrangements for the General Meeting of the Canadian Nurses Association in Saint John, June, 1932. Miss Retallick gave a report of an informal interview with Dr. Stewart Cameron in the interests of the formation of a Provincial Joint Study Committee. Short papers of most interesting content on phases of Public Health Nursing in New Brunswick were read by five Public Health nurses: "Duties of a Public Health Nurse," by Miss Jessie Murray, St. Stephen; "Technique of Bedside Nursing and Care of the Bag," by Miss McPhail, St. George; "A Day on the Tobique," by Mrs. W. L. Ross, of Riley Brook; "How a Voluntary Organization May Assist a Public Health Nurse with Her Duties," by Miss Agnes Hachey, Bathurst; and "The Care of the Premature Infant," by Mrs. Michaud.

The following resolutions were passed:

1. That the local chapters take up the matter of establishing hourly nursing services in their respective communities.

2. That all applicants of doubtful standing to provincial nursing schools be required to pass Grade X examination.

3. That further efforts to secure amendment to the Registered Nurse Act be postponed until after the Report of the Survey has been received and studied.

4. That Miss Margaret Murdoch and Miss Retallick be the two nurse representatives on the Joint Study Committee.

5. That the secretary of the Registered Nurses Association write the secretaries of the New Brunswick Medical Association, Hospital Boards and all institutions and organisations which employ nurses and ask that preference be given to New Brunswick Registered Nurses if available for duty.

6. That a resolution be sent from this annual meeting to the Workmen's Compensation Board asking the reason for placing the students in provincial schools of nursing under Workmen's Compensation.

Conveners of Sections and Committees elected for 1932: Public Health, Miss H. S. Dykeman, Health Centre, St. John; Private Duty, Miss Mabel McMullin, St. Stephen; Nursing Education, Sister Kerr, Hotel Dieu Hospital, Campbelltown; Constitution and By-Laws Committee, Miss S. E. Brophy, Fairville; "The Canadian Nurse," Miss A. A. Burns, Health Centre, St. John.

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Officers and Council Members: President, Miss A. J. MacMaster, Moncton Hospital, Moncton; First Vice-President, Miss Margaret Murdoch, General Public Hospital, Saint John; Second Vice-President, Miss E. J. Mitchell, 20 Millidge St., Saint John; Hon. Secretary, Mrs. W. S. Jones, Albert. Council Members: for Saint John, Misses Brophy, Coleman, Lawson and Dykeman; for St. Stephen, Misses J. Murray, McMullin; for Fredericton, Miss K. Johnson, Mrs. A. G. Woodcock; for Moncton, Misses M. Kay, M. MacLaren; for Campbelltonw, Sister Kerr, Miss G. M. Murray; for Chatham, Sister Kenny; for Bathurst, Miss M. E. Stuart; for Woodstock, Miss Elsie M. Tullock. Secretary-Treasurer-Registrar, Miss Maude E. Retallick, 262 Charlotte St. West, Saint John, N.B. Miss Margaret Murdoch was re-appoin ed to the Board of Examiners.

## THE MARITIME CONFERENCE, CATHOLIC HOSPITAL ASSOCIATION CONVENTION

With Reverend Sister Kenny of the Hotel Dieu Hospital, Chatham, N.B., as Chairman, the eighth annual convention of the Maritime Conference of the Catholic Hospital Association, which was held at Campbelltown, N.B., on August 26-28, proved one of the most interesting meetings in the history of the organisation. Distinguished visitors were: Rev. A. M. Schwitalla, President, Catholic Hospital Association; Dr. G. Harvey Agnew, Department Hospital Service, Canadian Medical Association; Rev. Mother Concordia and Sister M. Irene, St. Louis, Mo.; Rev. Mother Murray and Sister Helen Jarrell, St, Bernard's Hospital, Chicago; Sister St. James, Hotel Dieu Hospital, Kingston; Dr. M. M. Coady, Antigonish; and Mr. M. R. Kneifle, Secretary of the Catholic Hospital Association. In addition to several medical men of the province, the following contributed to the programme: Rev. A. M. Schwitalla, Dr. H. Agnew, and Sisters Jarrell, Kenny, Branch, Stanislaus and M. Beatrice, all registered nurses. The papers and addresses were interesting and instructive, the discussions were lively and the round table was efficiently conducted. Reports were received from the following active committees: Publicity, Nursing Education, X-Ray, Sodalities. An important feature of the Convention was the decision of the Association to send delegates to the proposed Canadian Hospital Council, which will be formed in Toronto on September 28th. Rev. R. Williams, St. Thomas College, Chatham; Mother Audet, Superior of the Hotel Dieu of St. Joseph, Campbelltown; and Mother M. Ignatius, of Bethany, Antigonish, were appointed as delegates to attend the initial meeting of the Canadian Hospital Council.

A hearty welcome to the delegates was extended by Rt. Rev. Monsignor A. Melanson, of Campbelltown, and by the Deputy Mayor of the town. The citizens of the town of Campbelltown placed their cars at the disposal of the visitors and delegates, who were entertained by the Sisters of the Hotel Dieu of St. Joseph and the Sisters of the Assumption. The delegates returned home favourably impressed by the cordial hospitality accorded them and were enchanted by the picturesque scenery of the many parts of New Brunswick which they visited.

The officers of the ensuing year are: President, Sister Kenny, R.N., Chatham, N.B.; First Vice-President, Sister M. Beatrice, B.A., R.N., Antigonish, N.S.; Second Vice-President, Mother Mary of the Sacred Heart, Chatham, N.B.; Third Vice-President, Sister Mary of the Sacred Heart, Sydney, N.S. Executive: Mother Audet, R.N., Campbelltown, N.B.; Mother M. Ignatius, R.N., Antigonish, N.S.; Sister Veronica, Saint John, N.B.; Sister John Baptist, Antigonish, N.S.; Sister Harquil, R.N., Campbelltown, N.B.; Secretary, Sister St. Stanislaus, B.A., Chatham, N.B.

## BOOK REVIEWS

**Eye, Ear, Nose and Throat for Nurses,** by Jay G. Roberts, Ph.G., M.D., F.A.C.S. Published by The Macmillan Company, Ltd., of Canada, Toronto. Price, $2.25.

In the prefare to this work the author quite correctly deplores the little attention paid to diseases of the eye, ear, nose, and throat in the curriculum of the average school of nursing. He points out that existing text books do not devote sufficient space to the subject. To remedy these deficiencies and to raise the standard of nursing in the departments of eye, ear, nose, and throat are the laudable reasons which prompted Dr. Roberts to prepare and publish this book.

It contains 200 pages and over 100 illustrations. It is well printed and easy to read. Points, often omitted from other text books, are discussed.

For a work that aims at providing a good reference and standard book for nurses, the arrangement of the various sections and subsections is not the best. It would have been better had the author followed the method adopted in all standard works, viz., the division of the work into four distinct sections rather than jumping from one to the other only to return back to them again. For example, would it not have been better had the external diseases of the eye been treated first and then the internal eye diseases? The author starts chapter v. with "Iritis," finishes with "Keratitis" and has "Conjunctivitis" and "Blepharitis" in between.

In view of the fact that the whole book is devoted to diseases of the eye, ear, nose, and throat, it is unfortunate that so meagre a description is given to conditions such as Sympathetic Ophthalmia, Trachoma, Gonorrheal Ophthalmia, etc. Sufficient importance cannot be attached to the technique in the treatment of these conditions by the nurse and the precautions she must take to prevent the spread of the infection to other patients or to herself. There is not an illustration in the book to show the Crede's method of treatment.

The book, as a whole, is unequal and in its present form is on too small a scale to be of as much value to the graduate nurse as might be the case. The expansion and rearrangement of the material would be an undoubted advantage.—M. R. L.

# News Notes

## BRITISH COLUMBIA

VICTORIA: At the last meeting of the Royal Jubilee Hospital Alumnae it was announced that Miss F. Helen Archer of Grand Forks Hospital was awarded a bursary of one hundred dollars for post-graduate work. The Alumnae have given this amount this year and plan to increase the bursary to at least two hundred for the following year. For this reason, efforts are being doubled in an attempt to make the coming winter a big success financially.

## MANITOBA

ST. BONIFACE: The official opening of St. Boniface Sanatorium took place on September 29th, in the presence of a distinguished gathering representing state, church, university, the medical and nursing professsion and a host of friends. This new institution for the care of the tubercular provides beds for 250 patients. With this additional space Manitoba has the largest number of beds for tuberculosis cases per capita of population in Canada. Other sanatoria are the Manitoba Sanatorium at Ninette and the Tuberculosis Clinic, Winnipeg.

## NEW BRUNSWICK

SAINT JOHN: Miss E. J. Mitchell was re-elected president of the Saint John Chapter of the New Brunswick Association of Registered Nurses at its annual meeting,held in the Lecture Hall of the General Hospital on September 28, 1931. Miss Mitchell in her address as president, cordially thanked the officers and members for their hearty support. The reports of the year's work were gratifying. After five years in office, as secretary, Miss Agnes Sutherland resigned, and appreciation of her service was expressed. The election of officers resulted as follows: President, Miss E. J. Mitchell; First Vice-President, Miss Ada Burns; Second Vice-President, Mrs. G. Van Dorser; Secretary, Miss E. Black; Treasurer and Registrar, Miss M. Fraser; Private Duty Section Convener, Miss Muriel McConnell; "The Canadian Nurse", Miss F. Townsend; Programme Committee, Miss Margaret Murdoch and Miss R. Wilson. Delegates to Women's Council were reappointed as follows: Mrs. O. A. Burnham, Mrs. John H. Vaughan, Miss E. J. Mitchell, Miss F. Coleman, Miss L. Gregory and Miss Mary Easson.

Mrs. G. L. Dunlop entertained a number of nurses in honour of Mrs. W. Sanson (Miss Elizabeth Brittain, Saint John General Hospital, 1915), who was on a visit in Saint John from her home in Cobalt. Much sympathy is extended to Mrs. G. Van Dorser in the loss of her father.

## NOVA SCOTIA

WINDSOR: Deep regret was expressed by the citizens of Windsor when on August 31, 1931, the death of Miss Margaret Martin, Superintendent of the Payzant Memorial Hospital, was announced. Miss Martin's death, which was due to cerebral haemorrhage, occurred shortly after she first became ill. Miss Martin was born in Guysboro County, N.S., and graduated as a nurse from Victoria General Hospital, Halifax. Following post-graduate work in Philadelphia and New York, she was engaged in institutional work in United States, later accepting the appointment of Superintendent of the Payzant Memorial Hospital. Miss Martin was greatly esteemed by all those with whom she came in contact and dearly loved by her student nurses and nurse associates. Members of the Board of Management, Women's Auxiliary, the graduates and student body, and many friends attended a funeral service which was held at Christ Church, Windsor. Interment was made in the family plot at Mulgrove, N.S., on August 25th.

Quoting from the Windsor paper: "Windsor was fortunate to have had Miss Martin's services for the time she was here. The development of the Payzant Memorial Hospital during that time and its present condition is surely a worthy monument to a noble life spent in the service of the highest welfare of the community. The floral tributes expressed the love, loyalty and affection of many."

## ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in October, 1931, were 966, forty-eight less than in September, 1931.

### APPOINTMENTS

PUBLIC GENERAL HOSPITAL, CHATHAM: Miss Jean Davis (1926) has resigned from her position as X-ray and Laboratory Technician, and is succeeded by Miss Hazel Simpson (1931). Miss Florence Quigley, Instructor, has resigned her position and will be succeeded by Miss Gertrude Myers, graduate of Brockville General Hospital, post-graduate of Children's Hospital, Cleveland, and University of Toronto.

GENERAL HOSPITAL, TORONTO: Miss Lillian Bailey (1923) has accepted the position of Medical Supervisor. Misses Marjorie Rowland (1929) Constance Sandwith (1930) and Margaret McKay (1930) have been appointed to the nursing staff.

### DISTRICT 1

The regular quarterly meeting of District No. 1, R.N.A.O. was held in Chatham, Ont., on October 15th, with Miss Nellie Gerrard in the chair. Rev. Mr. Calder opened the meeting with prayer and Mr. Thompson, civic manager, extended a very cordial welcome on behalf of the city. Dr. Ruther-

ford, representing the medical profession, welcomed the members and gave a short talk in which he assumed the role of critic. Noticing the numbers of older nurses at the meeting, he said there must be something wrong with an association which could not interest the younger members. Something should be done to remedy this as he believed the association to be a wonderful thing to which every graduate nurse should belong. In speaking of the over supply of nurses he thought, at present, superintendents would do young ladies a favour in discouraging them from entering schools of nursing. Mr. H. S. Thomas, of the Rotary Club, gave a very interesting paper on "The Service Club and its uses in a Community." Not only do those clubs elevate the ideals of the individual members but they accomplish wonders with the crippled children, and boys. Mr. G. H. Smith, Inspector of Public Schools for Kent County, gave a short talk on "Pre-Vocational Education," stating he thought matriculation a necessity before entering a school of nursing. At the close of the meeting the Alumnae Associations of Chatham General Hospital and St. Joseph's Hospital were hostesses at a delightful social tea hour.

PUBLIC GENERAL HOSPITAL, CHATHAM: At the annual graduation exercises of the Public General Hospital School of Nursing, held in Park Street United Church, Chatham, twelve nurses received diplomas and graduation honours. Miss Katherine Crackel was awarded the medal for general proficiency given by the Alumnae Association of the Public General Hospital. Hon. W. G. Martin, Minister of Public Welfare of the Province of Ontario, was the guest speaker. Following the exercises a reception was held at the Nurses Residence where Miss Campbell, Superintendent of Nurses, received with the members of the graduating class. After the reception a dance was held.

The annual picnic of the Alumnae Association was held at the home of Mrs. Archie Shanks, Port Alma. There were about fifty members present. A most enjoyable afternoon was spent in playing games and renewing acquaintances, after which lunch was enjoyed by all present.

The regular monthly meeting of the Alumnae Association was held on September 1st, with Miss W. Fair presiding, in the absence of Miss Head, the president. After the regular business was transacted, arrangements were made for the district meeting to be held in Chatham.

Miss Hazel Payne, 1930, has resigned from the staff of the Public General Hospital, Chatham.

DISTRICT 2

BRANTFORD: At the recent convention of the American Hospital Association held in Toronto, the Brantford General Hospital was awarded the certificate of merit for the North American Continent in connection with National Hospital Day observance. The following nurses attended the American Hospital Association meeting in Toronto: Misses E. M. McKee, J. M. Wilson, D. Arnold, F. Stewart, T. Dawson, S. Livett, G. Westbrook, K. Charnley, H. Muir, L. Gillespie, I. Marshall. Miss G. Van Fleet entertained at a miscellaneous shower on September 30th, in honour of Miss Audrey Roadhouse, whose marriage to Mr. Robert Hutton Malcolm, took place on October 12th. The Florence Nightingale Club was entertained at the home of Miss Clara Fisher on October 5th. The Alumnae Association of the Brantford General Hospital met in the Nurses Residence, October 6th, when Dr. W. W. Hughes gave a very interesting address on life in the British West Indies. Mrs. L. M. Norton, a recent post-graduate student of the Brantford General Hospital, and with the Victorian Order of Nurses, has registered for the Public Health Course at the University of Toronto. On September 14th, the student nurses, B.G.H., held a very successful garden party in the hospital grounds. Home made cooking, home made candy, soft drinks, weiners and rolls, and ice cream cones were sold. Dancing, a fish pond, and fortune telling were special features. About $100.00 was realised after all expenses were paid, and this amount was added to the Student Government Association funds. Miss Jessie McGregor (1914) Operating Room Supervisor, Harotin Polyclinic Hospital, Chicago, Ill., was a recent visitor in Brantford.

GENERAL HOSPITAL, GUELPH: Miss Mary Bliss, Superintendent, attended the annual convention of the American Hospital Association in Toronto.

A very successful tea and sale of home cooking and work was held on September 3rd at the Nurses Residence, under the auspices of the staff and student nurses. Miss Bliss, Miss MacDonald, and Miss Kenney were hostesses. Miss Kaemph, Miss Groenewald and Miss Speers poured tea which was served at small tables on the spacious porch, and were assisted by the student nurses. About $170.00 was realised. Miss Hazel E. Dennis (1923), and Miss A. L. Fennell (1919) are among the 1931-32 class at the University of Western Ontario, London, taking the Public Health Course for Nurses.

GENERAL HOSPITAL, GALT: Miss S. M. Jamieson attended the annual conventions of the American Hospital Association and the Ontario Hospital Association.

SIMCOE: Miss M. Buck, Superintendent, Norfolk Hospital, who recently underwent an operation for appendicitis has completely recovered. Miss Buck attended the conventions of the American Hospital Association and the Ontario Hospital Association in Toronto recently.

GENERAL HOSPITAL, WOODSTOCK: Miss Helen Potts and Miss A. M. McPhedran, Woodstock General Hospital, attended the convention of the American Hospital Association in Toronto. Miss Vida Burns (1913),

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of Middlebury, Conn., and Miss Agnes Weston (1918), of Albany, N.Y., have recently completed a course in School Nursing at the University of Toronto. Miss Annie Drake (1925), of New York, and Miss Jean Anderson (1930), of Detroit, were recent visitors at the Woodstock General Hospital. Miss Lenora Armstrong (1920) has returned to Korea where she is engaged in missionary work. Sincere sympathy is extended by members of the Alumnae to Miss Eleanor Hastings and Miss Martha Calvert on the death of their mothers.

DISTRICT 5

More than 125 members of District No. 5, Registered Nurses Association of Ontario, were present at a meeting held on September 19th, at Whitby. The nurses met at the Ontario Hospital, and were taken through the various wards and pavilions by Miss Bryan, Superintendent of Nurses, who explained the various treatments and apparatus used for these special patients. After tea, provided by the Hospital, the regular business meeting was held followed by a most interesting address given by Dr. McKenzie, of the Toronto General Hospital on "Brain Surgery."

Many Toronto nurses attended the recent convention in Toronto of the American Hospital Association, and enjoyed the wonderful exhibits. A publicity and information booth at the Royal York Hotel was staffed by relays of Toronto nurses. Miss Gunn, assisted by Toronto nurses, entertained at supper at the Royal York Hotel after the evening meeting of Nursing Section of the Association.

GENERAL HOSPITAL, TORONTO: Word has been received of the safe arrival in China of Miss Allegra Doyle (1929) and Miss Georgina Menzies (1929). Miss Doyle and Miss Menzies plan to remain in China for five years to engage in medical nursing.

HOSPITAL FOR SICK CHILDREN, TORONTO: During the American Hospital Association convention, Miss Austin entertained at tea and was assisted by Mrs. Bower and Mrs. Irving Robertson in receiving the guests. Miss Dorothy Mitchell (1929) has been awarded the Red Cross Scholarship for Public Health.

DISTRICT 5

WOMEN'S COLLEGE HOSPITAL, TORONTO: The September meeting of the Alumnae was held at Grenville St. Clinic. During the short business session the resignation of the Secretary, Miss Lottie Blair (1929), was presented and accepted with regret. Miss Blair is leaving to take a missionary course at the Moody Bible Institute, Chicago, in preparation for the foreign field. Miss Bolton (1924), who is home for some months, spoke to the members of her work in the Pine River District. Her talk was very interesting and instructive, and those present were once again assured that the Hospital spirit of helping the less fortunate was being well carried out in the western provinces. The meeting closed after the usual social tea. Congratulations are extended to Miss Jessie Patterson (1925), who passed her Summer School examination for school nursing.

## QUEBEC

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: Miss Jean Bancroft has resigned her position as Assistant Instructor, and has been replaced by Miss L. Beeman, Hospital for Sick Children, Toronto. Miss Sybil Gilling, of St. Joseph's Hospital, London, Ont., has been appointed to the nursing staff. Miss M. Flander and Miss R. Miller (1928) are attending the School for Graduate Nurses, McGill University, the best wishes of the Alumnae are offered to Misses Flander and Miller. Miss Vey, of Vancouver, Mrs. Peter Bartleman, of Asbestos, Que., and Mrs. F. McLean were recent visitors to the Hospital. Miss R. Paterson is again working with the Poliomyelitis Serology Department. Among the recent graduates to join the staff are: Misses B. Cleary, J. Argue, M. Ripley, B. Clarke, C. McIntosh, B. Gale.

THE MONTREAL GENERAL HOSPITAL: Misses Annesley, Ethel Cook and Edna Church (1928) have each been given a scholarship from The Montreal General Hospital and are attending the School for Graduate Nurses, McGill University. Misses Candlish, D. Murphy, Yule and Lilly (1930) are doing floor duty at the Montreal General Hospital. The engagenemt has been announced of Miss Marjory Taylor (1929) to Mr. Charles Woodside, of Buffalo, N.Y.

## SASKATCHEWAN

REGINA: On October 1st the second meeting of the year of the Regina Branch, Registered Nurses Association of Saskatchewan, was held at the Nurses Residence, with forty members present. After the usual business meeting, a bridge was very much enjoyed, having been arranged by the Executive.

The Executive of the Regina Branch, S.R.N.A., consists of: Hon. President, Mrs. W. M. Van Valkenburg; Hon. Vice-President, Miss Helen Smith; President, Miss M. McRae; First Vice-President, Miss H. McCarthy; Second Vice-President, Miss M. Buker; Secretary, Miss M. Munson; Treasurer, Miss D. Wilson; Registry Convener, Miss M. Phillips; Membership, Miss E. Pennock; Sick Nurses, Miss F. Linton; Press Reporter, Miss J. Campbell; Public Health, Miss Jean McKenzie; Education Convener, Miss Helen B. Smith; Entertainment, Miss K. Morton.

GENERAL HOSPITAL, REGINA: At the recent 1931 graduation exercises of the Regina General Hospital, forty-four nurses received their diplomas and the following awards were made: Henry Judson Crowe Scholarship for a University Course, Miss Helen Snedon; Dr. Low Gold Medal for General Proficiency, Miss Helen Snedon; Dr. Thomson Gold Watch for Obstetrics, Miss Jean McDonald; Dr. Stephens Gold Pin for Practical Work,

Miss Laura Balfour; Florence Nightingale Prize, choice made by the graduating class, Miss Emily Thiessen; Dr. Johnstone Prize for Surgical Nursing, Miss Helen Ross; and Dr. Gareau Prize for Pediatrics, Miss Alice Jewitt.

Miss Helen Snedon, gold medallist (1931), who was awarded the Crowe Scholarship, is taking the course in Public Health Nursing at the University of Toronto. Miss J. Bertwhistle (1931), chosen by the Victorian Order of Nurses for the Provincial Scholarship, is attending the same course at the University of Toronto. Miss Evelyn Bowman, former instructor of nurses, has accepted a position in the Vancouver General Hospital as clinical ward instructor. Miss Marian Myers, of the Montreal General Hospital, who has been instructor of nurses, Moose Jaw General Hospital, has been appointed instructor of nurses. Following the resignation of Mrs. Hugh Kennedy, graduate of the Hospital for Sick Children, Toronto, Miss Rossie Cooper, graduate of the same hospital, was appointed supervisor of the Children's Ward. Miss Cooper was formerly assistant night superintendent, and her position has been filled by Miss Mildred Munson (1930). Miss Laura Balfour (1931) has accepted a position on the operating room staff. Miss Jessie McGhie (1923), for four years a medical missionary at Camundongo, Portuguese West Africa, is home on furlough for a year. Miss Helen Lamb (1925) is on the staff of the Colony Hospital at Lorlie, Sask. The following nurses are taking post-graduate courses: Misses E. Stone (1931), in Operating Room Technique; D. Slack (1930), in the Obstetrical Department; D. Dobson Smith (1930), in Tuberculosis at the Saskatoon Sanatorium; and O. McDonald (1929), in Tuberculosis at Fort Sanatorium.

## VICTORIAN ORDER OF NURSES

TORONTO: The corn roast, which has been given for the nurses the last three years by Dr. Powell, a member of the Board, was held on the beach near Scarboro at the full moon in September. A very enjoyable evening was spent.

The fall meeting of the Staff Council, Toronto Branch, was held at Central Office, 281 Sherbourne St., on October 7th, with Miss Eva Bayne presiding.

The Victorian Order of Nurses for Canada at the request of the Department of Health, Toronto, arranged a two-day Institute on Maternal Care which was conducted by Miss Cryderman, Ontario Supervisor. This is the third Institute since March, 1931. There was an attendance of forty nurses. A short demonstration was given by Miss Muriel Winter, Toronto Branch, V.O.N., and the teaching Exhibit of the Mothers' Club, Toronto Branch, was displayed and discussed.

## BIRTHS, MARRIAGES AND DEATHS

### BIRTHS

BROCK—Recently, to Mr. and Mrs. A. Brock, of Port Perry, Ont. (Marguerite Jackson, Hospital for Sick Children, Toronto, 1929), a son.

CLARKE—In August, 1931, at Port Dover, Ont., to Dr. and Mrs. L. A. Clarke (Laura Irwin, Toronto General Hospital, 1925), a daughter.

CRAFT—On August 11, 1931, at Saint John, N.B., to Mr. and Mrs. Perry Craft (Jennie Straight, General Hospital, St. John), a daughter.

FARRELL—On July 6, 1931, at Hamilton, to Mr. and Mrs. Leslie Farrell (Katherine Bailey, Hamilton General Hospital, 1928), a son, Michael Shawn.

FAWCETT—On September 10, 1931, to Mr. and Mrs. Fred. E. Fawcett (Marion McLaughlan, Saint John General Hospital, 1927), a daughter.

FLEWELLING—In July, 1931, to Mr. and Mrs. Bertrum Flewelling (Ruth Carey, Saint John General Hospital, 1930), a son.

FRASER—On August 12, 1931, at Fredericton, N.B., to Mr. and Mrs. Earl Fraser (Lottie Wood, Victoria Public Hospital, Fredericton, 1928), a son.

FULLERTON—On July 25, 1931, at Truro, N.S., to Mr. and Mrs. B. L. Fullerton (Christine Higgins, Saint John General Hospital, 1924), a son.

HALL—On July 20, 1931, at Toronto, to Mr. and Mrs. Stanley Hall (Miss Akins, Women's College Hospital, Toronto, 1927), a daughter, Barbara Joan.

HILL—On August 9, 1931, at Hamilton, Ont., to Mr. and Mrs. Francis Hill (Laura Hunt, Hamilton General Hospital, 1927), a daughter, Elizabeth Anne.

KRUZNER—Recently, to Mr. and Mrs. Kruzner (Marie Peterson, Saint John Infirmary, 1928, formerly of the Victorian Order of Nurses Staff in Saint John), a daughter.

LACEY—Recently, to the Rev. and Mrs. Ed. Lacey, of Prescott, Ont. (L. Harding, Children's Memorial Hospital, Montreal, 1927), a son.

MASON—Recently, to Mr. and Mrs. Herbert Mason of Peterboro, Ont. (Violet McIntyre, Hospital for Sick Children, Toronto, 1929), a son.

McCAFFERY — Recently, at Oromocto, N.B., to Mr. and Mrs. T. McCaffery (Mary Holleran, Victoria Public Hospital, Fredericton, 1925), a daughter.

Institute of Public Health
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University of Western Ontario
LONDON - CANADA

McTAGGART—On September 30, 1931, at Toronto, to Mr. and Mrs. Donald H. McTaggart (Hazel Defoe, Toronto General Hospital, 1928), a son.

METCALFE—On September 18, 1931, at Toronto, to Mr. and Mrs. Metcalfe (Harriette Towne, Toronto General Hospital, 1929), a daughter.

O'DOWD—On August 2, 1931, at Hamilton, Ont., to Mr. and Mrs. T. J. O'Dowd (Myrtle Hammil, Hamilton General Hospital, 1920), a daughter.

SCOTT—On August 18, 1931, at Orangeville, Ont., to Dr. and Mrs. I. C. Scott (Jennie Bishop, Hamilton General Hospital, 1928), a son.

WILLIAMS—On September 15, 1931, at Toronto, to Mr. and Mrs. E. S. Williams (Doris Baldwin, Toronto General Hospital, 1929), a son.

WILSON—Recently, to Rev. Hugh and Mrs. Wilson (Laurel Shaw, Woodstock General Hospital, 1922), a son.

**MARRIAGES**

ADAMS—BASHAW—On September 26, 1931, at Chambly, P.Q., C. Jean Bashaw (Montreal General Hospital, 1928) to Captain F. T. Adams.

ALVING—FISHER—Recently, Dorothy M. Fisher (Hospital for Sick Children, Toronto, 1928), to Dr. Alfred Alving, of New York.

ANDERSON—PELTON—On September 9' 1931, at Toronto, Beatrice H. Pelton (Toronto General Hospital, 1923), to Edward Leonard Anderson, of Toronto.

BAKER—HEWITT—On September 5, 1931, at Toronto, Edna M. Hewitt (Toronto Western Hospital, 1924) to Harold Lloyd Baker.

BIELBY—STYNE—On April 10, 1931, Lottie Styne (Regina General Hospital, 1923), to Sidney Bielby, of Stenon, Sask.

BOOTH—KEIR—In August, 1931, at St. Catharines, Ont., Margaret Keir (Toronto General Hospital, 1928), to Arnold K. Booth, of Toronto.

CLINCH—SOMERVILLE—On September 19, 1931, Annie Viola Somerville (St. John General Hospital, 1927), to Archibald Gordon Clinch, of St. John, N.B.

CRAWFORD—DUNPHY—On September 22, 1931, at South Devon, N.B., Winifred Dunphy (Victoria Public Hospital, Fredericton, 1930), to Percy Crawford, of South Devon, N.B.

DEAN—JOHNSON—Recently, Hazel Jean Johnson (Hospital for Sick Children, Toronto, 1926), to Sidney Roscoe Dean, of Pittsfield, Mass.

DEVINS—WHATELY—In August, 1931, at Thornbury, Ont., Alice Carmeta Whately (Toronto General Hospital, 1927), to Dr. William Percival Devins, of Toronto.

DOUGLAS—COLLINS—On October 3, 1931, at Waterloo, Ont., Jean E. Collins (Toronto General Hospital, 1929), to William H. T. Douglas, of Toronto.

HILL—SIMPSON—On September 30, 1931, at Montreal, Rhoda Simpson (Montreal General Hospital, 1928) to Dr. Emerson Hill.

HORNCASTLE—MILLER—On September 18, 1931, at Montreal, Bernice Miller (Montreal General Hospital, 1926) to R. S. Horncastle.

HUTCHISON—KIRKHAM—On September 25, 1931, at Montreal, V. W. Kirkham (Montreal General Hospital, 1927), to Stanley Hutchison.

JAMIESON—HUGHSON—On July 11, 1931, at St. John, N.B., Margaret Lillian Agnes Hughson (St. John General Hospital, 1928), to Sydney Jamieson, of Dalhousie, N.B.

LAMB—ETTEY—On August 24, 1931, at Port Perry, Ont., Gwendolin Ettey (Toronto General Hospital, 1929), to Fred. Lamb.

McCANNEL—WATSON—Recently, Elsie Watson (Regina General Hospital, 1929), to Cecil McCannel, of Rosetown, Sask.

MOFFAT—POTTRUF—On July 1, 1931, at Southcote, Ont., Fern Pottruf (Hamilton General Hospital, 1927), to Roy Moffat, of Carluke, Ont.

MULDOON—SMART—Recently, Genevieve Smart (St. Joseph's Hospital, St. Thomas), to Robert Muldoon, of Caledonia, Ont.

ROSS—NOBLE—On September 29, 1931, Barbara Noble (Montreal General Hospital, 1929) to Dr. Malcolm Ross.

SOMERS—ROWE—On September 2, 1931, at Woodstock, Ont., Laura K. Rowe (Woodstock General Hospital, 1930), to Marley T. Somers, of Ingersoll, Ont.

STOREY—BEARANCE—On September 26, 1931, Ada Bearance (Regina General Hospital, 1929), to Norman Storey.

WELLER—PRINGLE—On July 18, 1931, at Toronto, Flossie Myrtle Pringle (Hamilton General Hospital, 1921), to Howard Weller, of Nobleton, Ont.

WEMP—SMYTHE—In July, 1931, at Chatham, Ont., Mrs. Edith P. Smythe (Public General Hospital, Chatham, Ont., 1925), to O. B. Wemp.

WERRY—McKINNON—In August, 1931, at Toronto, Helen McKinnon (Toronto General Hospital, 1927), to Gordon T. Werry, of Toronto

WRIGHT—GLEESON—In June, 1931, at Merlin, Ont., Pearl Gleeson (Public General Hospital, Chatham, Ont., 1925), to B. Wright.

WRIGHT—HENRIKSON—On September 21, 1931, at New York, E. M. Henrikson (Montreal General Hospital, 1929) to Leslie Wright ,of Horwick, P.Q.

## DEATHS

ESSEX—On August 25, 1931, at Toronto, Fanny Clendenning Essex (Toronto Western Hospital, 1919).

GREENAWAY—On April 29, 1931, at Edmonton, Alta., Mrs. A. Greenaway (Agnes Huston, Toronto Western Hospital, 1913), after a brief illness, pneumonia.

MARTIN—Suddenly, on August 23, 1931, at Windsor, N.S., Margaret Mundell Martin (Victoria General Hospital, Halifax) Superintendent of Payzant Memorial Hospital, Windsor, N.S.

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WANTED for the Old Ladies' Home, Halifax, N.S., on December 1st, a graduate nurse as Matron of the Home, and a trained housekeeper as Assistant. Applicants to apply, stating qualifications, age and salary, to the Secretary, Mrs. W. G. Watson, 40 Francklyn Street, Halifax, N.S.


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### A.A., ST. BONIFACE HOSPITAL, ST. BONIFACE, MAN.

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Meetings—Second Wednesday of each month, 8 p.m., St. Boniface Nurses Residence.

### A.A., WINNIPEG GENERAL HOSPITAL

Hon. President, Mrs. W. A. Moody, 97 Ash St.; President, Mrs. J. A. Davidson, 39 Westgate; First Vice-President, Mrs. S. Harry, Winnipeg General Hospital; Second Vice-President, Miss I. McDiarmid, 363 Langside St.; Third Vice-President, Miss E. Gordon, Research Lab., Medical College; Recording Secretary, Miss C. Briggs, 70 Kingsway; Corresponding Secretary, Miss M. Duncan, Winnipeg General Hospital; Treasurer, Mrs. H. I. Graham, 99 Euclid St.; Sick Visiting, Miss W. Stevenson, 535 Camden Place; Programme, Miss C. Lethbridge, 877 Grosvenor Ave., Membership, Miss A. Pearson, Winnipeg General Hospital.

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Meetings held first Thursday every month.

### GRADUATE NURSES ASSOCIATION, KITCHENER AND WATERLOO

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### A.A., BELLEVILLE GENERAL HOSPITAL

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Regular meeting held first Tuesday in each month at 3.30 p.m. in the Nurses' Residence.

### A.A., BRANTFORD GENERAL HOSPITAL

Hon. President, Miss E. Muriel McKee, Superintendent; President, Miss I. Marshall; Vice-President, Miss A. Hardisty; Secretary, Miss H. D. Muir, Brantford General Hospital; Assistant Secretary, Miss F. Batty; Treasurer, Miss L. Gillespie, 14 Abigail Ave., Brantford; Social Convener, Miss M. Meggitt; Flower Committee, Misses P. Cole and F. Stewart; Gift Committee, Mrs. D. A. Morrison, Miss K. Charnley; "The Canadian Nurse" and Press Representative, Miss E. M. Jones; Representative to Local Council of Women, Miss G. V. Westbrook.

### A.A., BROCKVILLE GENERAL HOSPITAL

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### A.A., ST. JOSEPH'S HOSPITAL, CHATHAM, ONT.

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### A.A., CORNWALL GENERAL HOSPITAL

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**A.A., ST. LUKE'S HOSPITAL, OTTAWA**

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**A.A., MEMORIAL HOSPITAL, ST. THOMAS**

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**A.A., GRANT MACDONALD TRAINING SCHOOL FOR NURSES, TORONTO, ONT.**

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### A.A., ST. JOHN'S HOSPITAL, TORONTO

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### A.A., ST. MICHAEL'S HOSPITAL, TORONTO

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses' Residence, Toronto Western Hospital.

### A.A., WOMEN'S COLLEGE HOSPITAL, TORONTO

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Meetings at 74 Grenville St., second Monday in each month.

### A.A., CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

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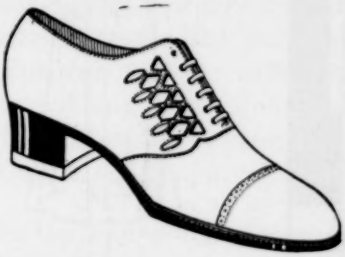

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